STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G171	A. BUILDING _____ B. WING _____	03/14/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARECO 11	4501 GRANT STREET, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS A revisit stemming from a death investigation was coupled with a recertification survey. The combined processes were conducted from February 28, 2006 to March 5, 2007. The results of the revisit are listed in a separate report. The facility's census at the time of the survey was seven, (one male and six females) with varying degrees of mental retardation. Four clients were selected for the sample. The survey was initiated utilizing the fundametal survey preocess; however due to concerns regarding the safety and health care of Client #2 the survey was extended in the conditions of Health Care Services and Client Protections. The facility's QMRP and management staff were notified that the survey was extended on March 3, 2007 at 11:30 a.m. to examine these conditons. In addition, an investigation into the health care of Client #2 was conducted in conjunction with the survey. The findings were based on observations at the group home and two day programs as well as the review of the medial and administrative records including the unusual incidents. It was determined, as a result of the survey process, that the facility was not in compliance with the conditions of participation in Health Care Services and Client Protections. Subsequent to completion of the survey process, the State Survey Agency received three (3) incidents of abuse and neglect on March 8, and March 12, 2007. On March 13th through 14th , 2007 the State Survey Agency conducted investigations relating to these incidents. Listed below are details regarding these incidents. Incident #1	W 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Marsha H. Thompson | Director of Disability Services | 4/10/07

An deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 000	Continued From page 1 On March 7, 2007, Staff #1 left the facility for an unspecified period of time, leaving her assigned 1:1 client without appropriate supervision. Incident #2 On March 7, 2007. Staff #2 left the facility for an unspecified period of time, leaving his assigned 1:1 client without appropriate supervision. Incident #3 On March 12, 2007, the group homes internal investigation findings revealed that Client #4 had been verbally abused by the house manager, which was witnessed by Staff #1 and #2. Based on interviews with the facility staff and one client, (Client #4), the aforementioned incidents of alleged neglect and verbal abuse were substantiated. Based on these findings, the facility's administrator was notified on March 14, 2007 at 3:45 PM, that it was not operating in compliance with two additional Conditions in Participation: Governing Body and Management and Facility Staffing.	W 000		
W 102	483.410 GOVERNING BODY AND MANAGEMENT The facility must ensure that specific governing body and management requirements are met. This CONDITION is not met as evidenced by: The facility's governing body failed to maintain general operating direction over the facility. [See W104] and failed to ensure outside services met client's needs. [See W120]	W 102	The Governing Body has taken steps to correct the deficient practices. The medical guardian who chose to use a different clinical team and PCP has agreed that the client must be discharged to a different provider. DDS was able to find a willing HCB Waiver provider. The discharge will be complete by April 15, 2007. The Governing Body has taken personnel actions against the manager and staff who disregarded company policy and the terms of the clients' ISPs. In addition, the Governing Body has hired a full time RN and a new Residential Director, and has completed recruit actions to bring on and train additional direct care staff. The Governing Body has also revised health care policies and has received technical assistance on them from the DCHRP. The Director of Disability Services has provided close supervision of the QMRP and additional training in management practices.	4-22-07

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W 102	Continued From page 2 The systemic effect of these practices results in the failure of the governing body to adequately manage and govern the facility and to ensure the Client protection and Safety [Refer to W122]; to ensure adequate staffing [Refer to W158]; and to ensure clients' receive health care services [Refer to W318].	W 102	The Governing Body reviewed and updated its previous policies and training practices concerning client protection and safety, and provided specialized training to all staff. Further, the Governing Body ensured that clients, their family members, advocates, guardians, and attorneys received copies of the revised policies.	4-22-07
W 104	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility.	W 104		
	This STANDARD is not met as evidenced by: Based on observation, interviews with staff, and the review of records, the facility's governing body failed to consistently provide operational direction over the facility as evidenced by the deficiencies cited in this report and the following: 1. Cross Refer to W149. The governing body failed to establish and implement policy and procedures to ensure that each clients well being is protected. 2.Cross-refer to W140. The governing body failed to establish and maintain a system that ensures a complete and accurate accounting of clients' funds that are entrusted to the facility. 3. Cross Refer to W159. The governing body failed to ensure that the Qualified Mental Retardation Professional (QMRP) coordinated services to meet the clients' needs. 4. Cross Refer to W120. The governing body failed to ensure that outside services were coordinated to meet the needs for as outlined in		The Governing Body has policy protecting staff who witness and report client neglect and abuse. All facility staff have been trained on this policy, and retrained on incident identification and reporting. The Governing Body's system to ensure complete and accurate accounting of client funds requires a) written requests and justifications for funds made by the RD or QMRP on behalf of clients; b) receipts to be provided for each expenditure other than clients' weekly cash allowance; c) receipts and other proofs of purchase be matched and reviewed by the accounting department by a date certain post the funds release; d) an accurate inventory of client possessions be maintained and updated when purchases are made. The DoDS provides training and close weekly supervision of the QMRP and the RD to ensure that services are coordinated to meet client needs. The Governing Body has revised Admissions, Discharge, Grievance, and Human Rights policies so clients/families/guardians who prefer services other than those provided by the facility can be properly and timely referred and discharged.	4-22-07 4-22-07 4-22-07 4-22-07

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/27/2007
FORM APPROVED
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W 104	Continued From page 3 Client #5's Individual Support Plan.	W 104		
W 120	483.410(d)(3) SERVICES PROVIDED WITH OUTSIDE SOURCES The facility must assure that outside services meet the needs of each client. This STANDARD is not met as evidenced by: Based on interviews with group home and record review, the facility failed to ensure that outside services met the medical needs for Client #2 and Client #5. The finding includes: 1. The Qualified Mental Retardation Professional (QMRP), the facility ' s Director of Nursing and House Manager were interviewed on February 28, 2007 at 4:00 PM. The interview revealed that the Primary Care Physician (PCP) for Client #5 was contracted by the client's sister, who was her legal medical guardian. The facility reported they were having problems communicating with the new PCP regarding the clients medical care needs. Review of the facility's policy related to professional contract services revealed that there must be a written agreement that specifies the responsibilities of the facility and an outside provider. It was stated by the facility ' s QMRP that at the onsite of the new PCP ' s services in September 2006, the former agency ' s Program Director had outlined for the new physician, the role and expectations necessary to meet the requirements of an individual that resides in an Intermediate Care Facility for the Mentally Retarded (ICF/MR) group home. However, since that time. the group home has experienced a lack of communication via written and/or phone call,	W 120	The Governing Body has contacted the PCP for client #2 face-to-face, in writing, and via telephone to explain the need for a contract in accordance with federal regulations governing ICFs/MR. Client #5's medical guardian (sister) reported that on April 6, 2007 the PCP signed the contract, however neither that document nor the other required documents have been provided to the facility, though requested. These documents include proof of insurance and a health certificate. The QMRP and the Director of Disability Services have coordinated a discharge meeting with the client's medical guardian, staff from DDS, and staff from another provider who has agreed to provide residential services to the client in a different residence funded under the HCB Waiver. The client will be discharged from the facility and will have moved to the new facility by April 15, 2007.	4/15/07

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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W 120	Continued From page 4 from the PCP. To date, the agency has been unsuccessful in obtaining a signed contract, proof of professional liability insurance, and annual certification that he/she is free from communicable disease, to ensure that the health, care and well being of client #5 is maintained. 2. The facility failed to ensure its dental services met Client #2's needs as evidenced by the following: Review of the dental section of Client #2 ' s medical record on March 2, 2007 at 10:45 a.m. revealed a consultation dated July 20, 2006 that indicated services were not rendered secondary to the expiration of the pre-authorization. On November 21, 2006, the client returned to the dentist and the consultant indicated that the client was not seen. No reason was indicated, however, there was a recommendation to " please sedate. " On January 18, 2007, the client was again seen by the dentist and the consultation report and revealed that that the client had " moderate calculus deposits " " patient needs scaling, " " Will submit pre-authorization. " Interview with the QMRP and the House manager on March 2, 2007, revealed that they rely on the dentist office to call and let them know when the office received the authorization for the appointments. The QMRP acknowledged the need for a better system to ensure dental appointments were completed timely.	W 120	The DoDS and the QMRP will meet with the DDS Dental Officer to request assistance with dentistry. The DDS Dental Officer provides the prior authorizations for dentistry for clients in the facility, so the facility will request the DDS dentist to ensure that community dentists provide the next appointment date for clients served, and that the prior authorization be written to cover the agreed-upon appointment date and the needed service for that date. The DoDS and QMRP will ensure that the facility's Human Rights Committee approves any recommended sedation in advance of the appointment date, and that clients' legal guardians sign informed consents for treatments that are either invasive or require sedation in order for the client to successfully complete the appointment. If the community dentist does not perform the prior-authorized service at the agreed upon appointment time, for clients who have been properly assessed for the need for sedation, the facility will report the occurrence to DDS and to DC Medicaid, and seek referrals to other community dentists who can meet the clients' dental health needs.	4/15/07
W 122	483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met.	W 122		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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W 122	Continued From page 5 This CONDITION is not met as evidenced by: Based on interview and record review, the facility failed to ensure that systems had been developed and implemented to: protect client privacy [Refer to W130]; provide clients with opportunities to participate in social, religious, and community group activities [Refer to W136]; establish and maintain a system that assures a full and complete accounting of funds entrusted to the facility [Refer to W140]; the facility failed to provide evidence of the prompt notification of parents or guardians of significant incidents [Refer to W148];establish and implement policies that ensure each client's health and safety [Refer to W149]; ensure that all incidents of potential negelect are thoroughly investigated [See W154]; and ensure that restrictive programs were used only with written consents [Refer to W263]. The effects of these systemic practices resulted in the failure of the facility to protect its clients from potential harm and to ensure their general safety and well being.	W 122	The facility has systems designed to meet all of the standards encompassed in this condition; the facility will ensure that all standards in this condition are met by assigning the DoDS to provide close oversight and supervision for the QMRP and the RD. The DoDS has recruited additional staff support to be trained in transportation policy and procedure, active treatment, client protections and safety, client rights, among other training requirements, specifically to ensure that clients are able to participate in social opportunities available to the community at large. A staffing pattern reflective of the supports clients need in order to attend and participate in social opportunities has been established. The Governing Body has developed and distributed revised policies on incident management, "whistle-blowing," and Human Rights. The facility staff have been trained on these policies, and constant mentoring and close supervision will be provided by the QMRP and the new Residential Director. When significant incidents are witnessed or discovered they are thoroughly investigated and reported promptly to parents, guardians, and oversight agencies per the facility's policy as evidenced by the recent discovery, reporting, investigation, and corrective measures taken for serious incidents (see Initial Comments and Response, W000) and the staff changes and training that have been documented. The facility is collaborating with the DCHRP on ensuring that health care policies are complete and appropriate; the DON and QMRP are implementing procedures to ensure health care needs are met. The QMRP has applied to DDS for guardians for the clients in the facility who are unable to make decisions regarding their own health care; a notification system and written informed consent process has been developed so that clients are made aware of risks and benefits of proposed restrictive treatments; the Governing Body has revised Human Rights policies and the QMRP has ensured all staff are properly trained on client privacy. See response to W104.	4/22/07
W 124	483.420(a)(2) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore the facility must inform each client, parent (if the client is a minor), or legal guardian, of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and of the right to refuse treatment. This STANDARD is not met as evidenced by: Based on observation, staff interview, and record	W 124		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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W 124	Continued From page 6 review, the facility failed to establish a system that would ensure that clients identified as unable to protect their own rights were assessed and provided established and legally sanctioned avenues to protect their rights for two of four clients in the sample. (Client #1 and #3). The finding includes: 1. On February 28, 2007, from 6:30 AM to 8:30 AM, Client #3 was observed to have a 1:1 staffing ratio. Interview with the 1:1 staff at 8:35 AM revealed that the 1:1 ratio was warranted during waking hours due to the clients behaviors of physical aggression, self- injurious behaviors, property destruction and disrobing. Interview with the House Manager, revealed that the client's sister was involved in her life but that the client did not have a legal guardian. Interview with the nursing staff on February 28, 2007 at 6:00 AM revealed Client #3 was prescribed medications for behavioral support. Review of Client # 3's physician's orders dated January 31, 2006, revealed the client was prescribed Trazadone 50 mg at bedtime, Paxil CR 2.5 mg at bedtime, Zyprexa 5 mg in the morning and Zyprexa 10 mg in the evening for behavioral support. Review of Client #3's, psychological assessment dated June 26, 2006, revealed that the client did not evidence the capacity to make independent decisions on her behalf regarding habilitation planning, placement, finances, treatment and medical matters. There was no evidence that client was informed of attendant risks of the medication treatment, and the right to refuse the medication treatment. 2. On February 28, 2007 from 6:30 AM to 8:30 AM, client #1 was observed to have one to one	W 124	The QMRP has submitted a guardianship request for this client to DDS. The client and her decision maker will be provided with written informed consent documents to be signed per the facility procedure. See response above.	4/22/07

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W 124	Continued From page 7 staffing supports. Interview with the House Manager on February 28, 2007 at 10;00 AM, revealed that Client #1's mother was involved in her life but that the client did not have a legal guardian. Interview with the nursing staff on February 28, 2007 at 6:00 AM revealed Client #1 was prescribed medications for behavioral support. Review of Client #1's physician's orders dated January 31, 2007 revealed the client was prescribed Seroquel 100mg in the morning, Seroquel 300mg in the evening and Buspar 15mg twice a day for behavioral support. Review of Client #1's psychological assessment dated July 9, 2006, revealed that the client did not evidence the capacity to make independent decisions on her behalf regarding habilitation planning, placement, finances, treatment and medical matters. There was no evidence that client was informed of attendant risks of the medication treatment, and the right to refuse the medication treatment.	W 124		
W 125	483.420(a)(3) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process. This STANDARD is not met as evidenced by: Based on interviews and record review, the facility failed to ensure that individuals who lacked the capacity to make informed decisions had received assistance with identifying a surrogate decision-maker for habilitation and treatment needs, and the client's right to file complaints	W 125	The Governing Body has revised the Human Rights, Admissions, Discharge, and Grievance policies. Further, the facility has redeveloped its Human Rights Committee to ensure that clients' rights are protected, and that families and decision makers have a forum and supports for further education, investigation of grievances, and giving or withholding consent for treatment. Staff and clients will be trained together on these policies, and family members and decision makers will be invited to attend.	4/22/07

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W 125	Continued From page 8 which was not honored /trained to do so, for four of the four client's in the sample (Clients #1,#2, #3 and #4) and focused client. (Client #5) The findings include: 1. Cross Refer to W124. On March 3, 2007 , a review of Client #1's Habilitation records was conducted. Client #1 was receiving psychotropic medications and had a Behavior Support Plan (BSP) for the management of stereotyped behaviors. Interviews and record review, however, failed to show evidence that the attendant benefits and risks associated with using the treatments or their right to refuse had been explained to Client #1. Further interview with the House Manager and Qualified Mental Retardation Professional (QMRP) revealed that Client #1 did not have a legal guardian or a surrogate decision maker to assist her in decision making. Further record review failed to show documented evidence that the facility attempted to secure an appropriate surrogate decision-maker or guardian, to ensure that Client #1's rights were protected. 2. Cross Refer to W124. On March 1, 2007 , a review of Client #3's records was conducted. Client #3 was receiving psychotropic medications and had a BSP for the management of stereotyped behaviors. Interviews and record review, however, failed to show evidence that the attendant benefits and risks associated with using the treatments or their right to refuse had been explained to Client #3. Further interview with the House Manager and the QMRP revealed that Client #3 did not have a legal guardian or a surrogate decision maker to assist her in decision making. Further record review failed to show	W 125	The QMRP has submitted a request to DDS for assignment of a guardian. The client and her family/decision maker will be invited to attend the training on the facility's Human Rights, Admissions, Discharge, and Grievance policies, and will be provided with copies. The client and her family member/decision maker will be provided with the written description of proposed treatment with its risks and benefits so that signed informed consent or withholding of consent can be executed and made part of the client's record. See response above.	4/22/07

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W 125	Continued From page 9 documented evidence that the facility attempted to secure an appropriate surrogate decision-maker or guardian, to ensure that Client #3's rights were protected. 3. On March 7, 2007 and on March 12, 2007, three incident reports alledging neglect and verbal abuse were received at the Department of Health. On March 13-14, 2007 interviews conducted with the facility staff and with one client(#4), revealed that the facility had failed to ensure her protection from any form of reprisal or intimidation as a result of a complaint or grievance reported. Interview with Client #4 on March 13, 2007 revealed she was fearful and had been spoken too harshly and threaten harm by a facility staff (House Manager). Interview with direct care staff verified the clients' complaint that her rights were being violated, however voiced that she was not always understood because of her speech barriers. A review of her Habilation Record on March 14, 2007 revealed that Client #4 did not have a legal guardian or a surrogate decision maker to assist her in decision making and/or to file a complaint. According to the QMRP and the agency administrator, client #4s contact with her mother is limited to telephone contact only. Client #4 told the surveyors that her mother said that she had heard (source unknown) that she (Client #4) was mad at the house manager. Futher record review failed to show documented evidence tha the facility attempted to secure an appropriate surrogate decision-maker or guardian, to ensure that client Client #4's rights were protected.	W 125	The DoDS received notification from HRA Surveyors that client #4 had been verbally abused by the Residential Director. The RD was already on administrative leave while another incident was being investigated. As soon as the DoDS was made aware of the threat, she telephoned the police and encouraged client #4 to make a telephone complaint, then receive a visit in person to file her complaint. Further, the DoDS called the OIG to report the incident and ask for an investigation to be opened. The DoDS had an interview with an officer of the OIG, and set up interviews with the client and staff reporters. The DoDS recommended the immediate termination of the RD, and the Director of Operations effectuated the personnel action. The DoDS was able to make contact with client #4's mother a day later when she called the client. The DoDS informed the mother of the incident and had a personal meeting with her to follow up. Client #4 since has been home to visit her mother for Easter, and her mother has been to the facility to accompany her to a medical appointment with the DoDS. The DoDS also had a follow up discussion with the mother on April 10, 2007. The QMRP has submitted a request to DDS to assign a legal guardian for client #4.	4-22-07
W 130	483.420(a)(7) PROTECTION OF CLIENTS RIGHTS	W 130		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G171	A. BUILDING _____ B. WING _____	03/14/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARECO 11	4501 GRANT STREET, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 130	Continued From page 10 The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs. This STANDARD is not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure privacy during treatment and care of personal needs for one of the four clients included in the sample. (Client #3) The findings include: 1. Observations on February 28, 2007 at 7:20 AM Client #3 was observed sitting on the sofa in the living room area. She was observed to jump up quickly, start laughing and dropped her pants to the floor. Staff were observed to pull her pants up and resit her on the sofa. At 7:35 AM, Client #3 was again observed to jump up from the sofa, and push her pants to the floor. At this time it was observed that she had no underwear on, however staff still pulled her pants up and sat her back on the sofa. At 7:45 AM Client #3 was standing in front of the sofa with no pants on. Staff seated her on the sofa and preceded to dress her while sitting on the sofa. As staff tried to assist her, the client attempted to bite the female staff on her breast. It should be noted that three other clients and 2 additional staff were observed in the den area during the observation. During evening observation At 3:00 PM, Client #3 was observed sitting on the sofa again. Her assigned one to one staff (male) was standing by the sofa with three peers and two staff close by. Client #3 was observed repeatedly, jump up quickly from the sofa and remove her shirt and her pants. Staff immediately redressed Client #3	W 130	The psychologist has been consulted about the client's challenging behaviors; her BSP has been revised and staff have been trained on the revised protocols. The Human Rights Committee will reconsider her behavioral support needs to ensure her rights and dignity are protected, as well as her preferences to the greatest extent safely possible. Client #3 will be assessed by the QMRP, RN, and DoDS to determine what environmental factors may be triggering her sudden outbursts, physical aggression and SIB.	4-22-07

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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W 130	Continued From page 11 however, failed to ensure her right to privacy by redressing her in the living room. Interview with the one to one staff revealed that "disrobing" was identified as one of her target behaviors, which is addressed in a behavior support plan. It should also be noted that Client #3 was observed without underwear and a bra on. On March 1, 2007 at 7:15 AM, a review was conducted of the facility's Human Rights Committee minutes. On September 28, 2006, Client #3's June 22, 2006 behavior support plan had been reviewed and approved to include procedures on how to manage disrobing. The following steps were to be implemented: Staff should address disrobing by keeping client engaged in a task as soon as possible. When <client> begins to disrobe, staff should verbally direct her to stop. If disrobing continues, <client> should be escorted to her bedroom or to the bathroom by female staff and verbally prompted to put her cloths back on. 2. On March 13, 2007 at 3:00 PM, surveyors entered into the facility. Four consumers and one male staff were observed in the den area. Client #3 was observed sitting on the sofa, totally naked. No clothing was observed close by where she was sitting. The male staff (substitute), who was providing 1:1 supervision for client #1, jumped up from working with his assigned client at the table and greeted the surveyors. According to the staff, the facility was experiencing a shortage of staff and he was helping to provide coverage. Further interview revealed that today (March 13) was his first day in the facility. The staff person and the surveyors had to locate the facility nurse in the office to inform her that Client #3 was sitting in the den with no clothing. The nurse alerted the other	W 130		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/27/2007
FORM APPROVED
OMB NO. 0938-0391

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W 130	Continued From page 12 staff in the back to assist with the client. The staff escorted her from the area and shortly returned with her clothing on. Interview with both staff could not determine how long Client #3 had been sitting naked in the den. There was no evidence that the QMRP had ensure adequate staffing supports and training to ensure that Client #3's rights had been protected.	W 130		
W 136	483.420(a)(11) PROTECTION OF CLIENTS' RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients have the opportunity to participate in social, religious, and community group activities. This STANDARD is not met as evidenced by: Based on observation, staff interview, and record review the facility failed to provide varied community opportunities for one of four clients in the sample (Client #4). The finding includes: On February 28, 2007,Client #4's hair was observed to be ungroomed. Interview with the day program staff later that morning, indicated that her hair always looked ungroomed. Interview with Client #4 revealed on the same day around 11:00 AM revealed that she wanted to go to an outside beauty palor to have her hair done. Interview with staff and record review failed to provide evidence that the client was regularly going to the hair salon. Staff stated that the client's hair is maintained by the direct care staff.	W 136	The DoDS will consult with the DON to select a beauty salon for client #4's hair care. The DON suggests that specialists who work in medical facilities would have the skills necessary to properly and attractively groom the client's hair. If this proves unsatisfactory to the client, the QMRP will ask the client if she would like to have her nails done in the salon, but have her hair done by the professionals in medical settings to better care for it.	4-20-07
W 140	483.420(b)(1)(i) CLIENT FINANCES	W 140		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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W 140	Continued From page 13 The facility must establish and maintain a system that assures a full and complete accounting of clients' personal funds entrusted to the facility on behalf of clients. This STANDARD is not met as evidenced by: Based on staff interview and review of records, the facility failed to establish and maintain a system that ensures a complete and accurate accounting of clients' funds that are entrusted to the facility for four of the four clients included in the sample. (Clients #1, #2, #3 and #4) The findings include: Review of Client #1, #2, #3 and #4's financial records on March 5, 2007 at 10:00 AM revealed several withdrawals from their accounts between September 21 and 28, 2006. A review of each clients' record revealed that a withdrawal for $292.50 and $100 dollars, totaling $392. 50. Interview with the House Manager (HM) on March 5, 2007 at 2:30 PM revealed that the Qualified Mental Retardation Professional (QMRP) had been working with a vacation planner, and the sum above had been withdrawn for payment of vacation rental and the rest for spending money, however the trip never occurred. Interview with the QMRP later that afternoon confirmed that the vacation had been cancelled and the monies should have been re-deposited into each clients account. At the time of the survey, the facility was unable to account for the $392.50 withdrawn for each client.	W 140	See response to W104 #2. All client funds were accounted for with receipts. The receipts were maintained at the office, and the QMRP maintained copies as well. Copies will be filed at the facility as well.	4-22-07
W 147	483.420(c)(5) COMMUNICATION WITH CLIENTS, PARENTS &	W 147		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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W 147	Continued From page 14 The facility must promote frequent and informal leaves from the facility for visits, trips, or vacations. This STANDARD is not met as evidenced by: Based on staff interview and record review the facility failed to ensure that each client was offered a choice in vacation outing. The finding includes: Cross refer to W140. Review of Client #1, #2, #3 and #4's financial records on March 5, 2007 at 10:00 AM revealed several withdrawals from their bank accounts between September 21 and 28, 2006 for a planned vacation. Interview with the House Manager (HM) on March 5, 2007 at 2:30 PM revealed that the Qualified Mental Retardation Professional (QMRP) had been working with a vacation planner and that a trip package had been submitted and approved. The monies specified for the vacation had been withdrawn for payment of the vacation rental and additional monies had been requested and withdrawn for spending money. The vacation, however, never occurred and there was no evidence that the clients had been afforded the opportunity to go on an annual vacation as recommended.	W 147	The QMRP has planned and clients have paid for a vacation. The vacation is to occur during the month of April 2007. The DoDS interviewed clients, and those who were able to express their preferences indicated their satisfaction with the planned trip. Two clients are being discharged from the facility; their expenditure will be refunded.	4/22/07
W 148	483.420(c)(6) COMMUNICATION WITH CLIENTS, PARENTS & The facility must notify promptly the client's parents or guardian of any significant incidents, or changes in the client's condition including, but not limited to, serious illness, accident, death, abuse, or unauthorized absence.	W 148		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
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W 148	Continued From page 15 This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility failed to provide evidence of the prompt notification of parents or guardians of significant incidents, for three of the four clients in the sample (Client #1, #2, #4) and one focus client. (Client #5) The finding includes: On March 7, 2007 and on March 12, 2007, the State Agency received three incident reports alleging neglect and verbal abuse. On March 13-14, 2007 interviews conducted with the facility staff and with one client(#4), revealed that the facility had failed to ensure the client's protection from any form of reprisal or intimidation as a result of a complaint or grievance reported. Interview with Client #4 on March 13, 2007 revealed she was fearful and had been spoken too in a mean tone and threaten harm by a facility staff (House Manager). The client indicated that she had voiced her concerns to Direct Care Staff #1. Interview with direct care staff #1verified the clients' complaint that her rights were being violated, however voiced that the client was not always understood. A review of her Habitation Record on March 14, 2007 revealed that Client #4 did not have a legal guardian or a surrogate decision maker to assist her in decision making and/or to file a complaint, however her mother remains in contact (limited) with her via telephone calls. In addition there was no evidence that Client #4's mother had been informed of the this incident. According to the agency administrator, they were unable to make contact	W 148	See responses to W104 and W125.	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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W 148	Continued From page 15 This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility failed to provide evidence of the prompt notification of parents or guardians of significant incidents, for three of the four clients in the sample (Client #1, #2, #4) and one focus client (Client #5) The finding includes: On March 7, 2007 and on March 12, 2007, the State Agency received three incident reports alleging neglect and verbal abuse. On March 13-14, 2007 interviews conducted with the facility staff and with one client(#4), revealed that the facility had failed to ensure the client's protection from any form of reprisal or intimidation as a result of a complaint or grievance reported. Interview with Client #4 on March 13, 2007 revealed she was fearful and had been spoken too in a mean tone and threaten harm by a facility staff (House Manager). The client indicated that she had voiced her concerns to Direct Care Staff #1. Interview with direct care staff #1verified the clients' complaint that her rights were being violated, however voiced that the client was not always understood. A review of her Habitation Record on March 14, 2007 revealed that Client #4 did not have a legal guardian or a surrogate decision maker to assist her in decision making and/or to file a complaint, however her mother remains in contact (limited) with her via telephone calls. In addition there was no evidence that Client #4's mother had been informed of the this incident. According to the agency administrator, they were unable to make contact	W 148		

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W 148	Continued From page 16 with Client #4's mother due to the facility having an inaccurate telephone number. It was also determined as a result of interviews with the facility's direct care staff that alleged three additional clients (Clients #1, #2, and #5), had been verbally abused by the house manager. Interview and record verification revealed that all three clients have active family and/or legal guardians and there was no documented evidence that the facility had informed them of the aforementioned allegations of abuse.	W 148	The QMRP has notified all families and guardians that the previous RD verbally abused the clients.	4-22-07
W 149	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility failed to develop and implement its established policies to ensure the health and safety for four of the four clients in the sample. (Clients #1, #2, #3 and #4). The findings include: 1. The facility failed to ensure adequate supervision (1:1) as indicated by individual support plans as evidenced below: On March 12, 2007, the facility had identified and forwarded an incident report to the State Agency, that alleged that client #4 had been subjected to verbal abuse by the facility's house manager, which was witnessed by the two employees.	W 149	The QMRP, DoDS, and Director of Operations were unaware of the verbal abuse. The DoDS interviewed several of the staff who made the allegations and discovered that they had mentioned concerns, if not specifics, to the previous Program Director. Each staff person stated that the Program Director had confronted the RD and given the staff accuser's name. Staff reported that the RD was able to plausibly deny any abuse, and that staff who had reported were usually fired on some pretext later on. As a result of these interviews, the Governing Body developed a "Whistle-Blower" policy protecting staff who report incidents. All staff have been trained on this policy, it has been provided to clients, and will be mailed or otherwise transmitted to families and guardians. The Governing Body also reviewed and revised the Human Rights Policy, Grievance Policy, and Incident Management Policy, and will provide training on each to all staff.	4-22-07

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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W 149	Continued From page 17 On March 13. 2006 at approximately 3:00 PM, client #4 was interviewed to verify if she had been verbally abused. Client #4 revealed that she had been spoken too in a mean manner by the house manager and was afraid of her. She further stated that she had been threaten with physical harm by the house manager, if she said any thing to anyone about things going on in the house. On March 13, 2007 around 4:15 PM, staff were interviewed which verified the clients statement that the house manager had interacted inappropriately (verbally) with client #4. During the course of staff interviews, it was reported, that 3 additional clients had also been subjected to inappropriate comments referencing these residents as "Lip Tracy", "big black gorilla", and telling a client to "go around the corner to your crack head mommas's house". Staff stated that they knew that these comments were abusive and wrong. The staff however failed to report the abuse as required in the agencies policy and procedures. All direct care staff interviewed and witnessed the abuse stated that their jobs had been threaten and felt that administration would not support them if they reported the abuse. Staff also stated that they had received training on abuse and neglect and had been instructed to document all allegations of abuse on Unusual incident reports. Review of the agency's policy and procedures on Abuse and Neglect classified that verbal abuse as a "misdemeanor." When the surveyors brought the aforementioned allegations to the administrators attention on March 14, 2007 at 3:20 PM, it was acknowledge that the agency was unaware of the other clients verbal abuse. It was also determined that the reported allegations were not reported to the police. Based on the surveyors inquiery, the facility administrator made contact with the police to file an report on March	W 149		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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W 149	Continued From page 18 14, 2007, at 3:30 PM. The administrator also informed the surveyors that the agencies investigation had been completed and recommended the termination of the house manager. The administrator also reported that the agency's policy and procedures needed revisions to include employee protection and reporting methods for employees who have witnessed abuse. 2. The facility failed to provide effective monitoring to ensure Client #2's health and safey. On February 28, 2007, at 9:00 a.m. Client #2 was observed sitting in the living room area with the direct care staff and his peers. Interview with the residential manager at 10:00 a.m. revealed that Client #2 would not be attending his day program because he had a medical appointment. Further interview with the residential manager revealed that Client #2 had just had abdominal surgery. Interview with the Designated Nurse and the QMRP on the same day revealed that Client #2 had an esophogastroduodinoscopy (EGD) as an outpatient on January 24, 2007 and a foreign body was observed in the stomach. In an attempt to remove the foreign body, the client aspirated. Client #2 received emergency surgery to remove the foreign body. According to the operative report, twelve (12) plastic bags were removed from the clients stomach. Further interviews with the Designated Nurse and QMRP on March 3, 2007 at 3:00 p.m. revealed that it was not known how the client came to have access to the plastic bags. Interview with direct care staff #1 on March 5, 2006 revealed that Client #2 was capable of reaching objects that he wants. Review of the facility's internal investigation into this matter failed to evidence interviews and/or possible	W 149	The QMRP completed an initial investigation on the incident of the client ingesting pieces of a plastic bag. The QMRP obtained a picture of the ingested material that appears to show bite-sized pieces of black plastic, not separate black plastic bags as originally reported/thought. The facility's Incident Management Coordinator tried on several occasions to interview the two doctors who were managing the client's care when the plastic was removed from his stomach surgically. Neither physician provided a comprehensive interview or report. The surgeon did say that he could not tell how long the plastic had been in the client's stomach, only that it was embedded there. The DoDS convened a case conference to discuss the incident and its implications. It was determined that although the client has a history of PICA, he has not demonstrated the behavior for 5 years. Although he has been observed to be active and reaches for what he wants, he would not normally be in a position to reach for and ingest plastic. A number of scenarios were discussed among the attendees, who included representatives from the facility, the DCHRP, DDS, ULS, and the Evans Monitoring office. Evidence of this meeting is available for review.	4-22-07

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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W 149	Continued From page 19 theories as to how the client came to have 12 plastic bags in his stomach. 3. The facility failed to implement its policy on the receipt and disposition of all controlled substances. [SeeW337]	W 149	The DON has reviewed with the nurses the facility policy on receipt and disposal of controlled substances.	
W 154	483.420(d)(3) STAFF TREATMENT OF CLIENTS **The facility must have evidence that all alleged violations are thoroughly investigated.** This STANDARD is not met as evidenced by: Based on observation, interview and record review the facility failed to perform a thourough investigation into the possible causes of how Client #2 ingested foriegn bodies. The finding includes: On February 28, 2007, at 9:00 a.m. Client #2 was observed sitting in the living room area with the direct care staff and his peers. Interview with the residential manager at 10:00 a.m. revealed that Client #2 would not be attending his day program because he had a medical appointment. Further interview with the residential manager revealed that Client #2 had just had abdominal surgery. Interview with the Designated Nurse and the QMRP on the same day revealed that Client #2 had an esophogastroduodinoscopy (EGD) as an outpatient on January 24, 2007 and a foreign body was observed in the stomach. In an attempt to remove the foreign body, the client aspirated. Client #2 received emergency surgery to remove the foreign body. According to the operative report, twelve (12) plastic bags were removed from the clients stomach. Further interviews with	W 154	The facility Incident Management Coordinator has received information from the two physicians who had care of the client during the discovery and removal of the foreign object in his stomach. The incident investigation is complete as of 4/11/07. See Response to W149.	4-22-07 4-22-07

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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CARECO 11	4501 GRANT STREET, NE WASHINGTON, DC 20019

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W 154	Continued From page 20 the Designated Nurse and QMRP on March 3, 2007 at 3:00 p.m. revealed that it was not known how the client came to have access to the plastic bags. Interview with direct care staff #1 on March 5, 2006 revealed that Client #2 was capable of reaching objects that he wants. Review of the facility's internal investigation into this matter failed to evidence interviews and/or possible theories as to how the client came to have 12 plastic bags in his stomach.	W 154		
W 158	483.430 FACILITY STAFFING The facility must ensure that specific facility staffing requirements are met. This CONDITION is not met as evidenced by: Based on observations, staff interviews, and record review, the facility failed to ensure that each client's active treatment program was integrated, coordinated and monitored by the Qualified Mental Retardation Professional (QMRP) [See W159]; and failed to ensure sufficient staffing and supervision to effectively monitor clients and address their needs [See W186]; the facility staff failed to demonstrate competency in implementation of Client's Behavior Support Plans [See W193] The effects of these systemic practices results in the facility's failure to ensure the availability of adequately trained staff to ensure the clients' health, safety, and well being. [See also W102 and W122]	W 158	The facility was inadequately staffed during the time of the survey, as in the discovery of incidents of verbal abuse and allegations of shift abandonment by both the RD and direct care staff, the DoDS had to place full time trained staff members on administrative leave, and the RD had to be terminated. Further, at least one client had to be kept at home for recuperation, meaning staffing for the day shift had to be increased. The DoDS and the QMRP had to work shifts in the home and implement recruit actions to quickly bring on and train staff to help support clients while the regular staffing pattern was completely revised. The DoDS, QMRP, and RD are collaborating with the facility Human Resources Director to re-map and re-staff the facility according to much higher demand and changing population size (two clients are being discharged from the facility). The DoDS is also working with Human Resources to develop an "on-call" list of trained staff who are available to work at the home upon short notice.	
W 159	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a	W 159		4-20-07

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G171	A. BUILDING _____ B. WING _____	03/14/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARECO 11	4501 GRANT STREET, NE WASHINGTON, DC 20019

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W 159	Continued From page 21 qualified mental retardation professional. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility's Qualified Mental retardation Professional (QMRP), failed to adequately monitor integrate and coordinate each client's active treatment. The findings include: 1. The QMRP failed to ensure that outside services met the needs of each client. [See W120] 2. The QMRP failed to ensure continous active treatment. [See W249] 3. The QMRP failed to ensure each client ' s privacy during personal needs. [See W130] 4. The QMRP failed to ensure Client's received timely medical services. [See W322.2] 5. The QMRP failed to ensure clients receive timely dental services. [See W356] 6. The QMRP failed to ensure the availability and maintenance of adaptive equipment [See W436] 7. The QMRP failed to ensure that an alternative schedule was developed for clients not attending day programs to ensure consistent programing. [See W250] 8. The QMRP failed to provide evidence of the prompt notification of parents or guardians of significant incidents. [See W148]	W 159	See response to W120. The DoDS has and will continue to provide the QMRP with close supervision and support to ensure continuous active treatment is implemented. See response to W130. See response to W120. See response to W120. The QMRP has ensured equipment is purchased, staff are trained, and policy is implemented. Adjustments to equipment have been requested as appropriate. The QMRP has developed alternative scheduling for clients not in attendance at day programming. The DoDS has retrained the QMRP and Incident Mangement Coordinator and has trained the new RD on incident notification.	4-22-07 4-22-07 4-22-07

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/27/2007
FORM APPROVED
OMB NO. 0938-0391

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	09G171	A. BUILDING _____ B. WING _____	03/14/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARECO 11	4501 GRANT STREET, NE WASHINGTON, DC 20019

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W 159	Continued From page 22 9 The QMRP failed to ensure the Mealtime Protocol/Guidelines for Client #2 had been revised to reflect changes recommended/ordered as evidenced below: On February 28, 2007, at 4:15 p.m. Client #2 was observed receiving water in the livingroom area. The fluid was thickened and presented to the client in a regular cup. The client was observed to cough intermittently while receiving the liquid. Interview with the Qualified Mental retardation Professional (QMRP) on March 2, 2007 at 2:00 PM revealed that the client was on a "chopped with ground meats" diet until he received a Swallow Study on January 4, 2007, which revealed that the Client had 'moderately severe oropharyngeal dysphagia. The safe food textures recommended was creamy or thick pureed. and the safe liquid consistencies was honey. The swallow function report also indicated that the liquids should be given by spoon only. The QMRP nor the nurse could explain why the client did not receive his liquids via spoon as recommended by the Speech and Language Pathology report. It should be noted that there was no evidence that the Primary Care Physician had reviewed the report.	W 159	The QMRP and Registered Dietician retrained all staff on food preparation and presentation for client #2. The DoDS mentored and demonstrated dining protocols for client #2 for all staff until they can assist him to eat safely.	4-22-07
W 186	483.430(d)(1-2) DIRECT CARE STAFF The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans. Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit.	W 186	See response to W158	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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	09G171	A. BUILDING _____ B. WING _____	03/14/2007

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W 186	Continued From page 23 This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure consistent one-on-one staff coverage in accordance with the individual plan, for two clients (Client #1 and #3) and failed to ensure there were sufficient care staff to meet the needs of client #2. The findings include: 1. The facility failed to ensure consistent one-on-one staff coverage in accordance with their individual support plans, for two of the three clients that reside in the facility. On March 8, 2007, an unusual incident report was received alleging client neglect. Through staff interview and record review on March 13, 2007 the allegation was substantiated based on the following: On March 13, 2007, interview with the direct care staff verified that on March 7, 2007, two direct care staff left the facility to buy food; leaving two staff in the facility to care for seven clients. Three of the clients required 1:1 supervision, and one client required additional close supervision secondary to a recent surgery. Interview with the facility administrator, on March 14, 2007 around 3:30 PM, acknowledged that the facility had been initally short of staff and the staff failed to adhere to agency policy on staff coverage. 2. The facility failed to effectively supervise Client #2 to ensure safey and prevent harm.	W 186	See responses to W000, W104, W122, W130, W148, W149, W154, W158, and W159 1. The RD had four staff assigned to the shift; clients were to remain at home due to inclement weather. The RD neglected to call in additional staff to support the clients at home. She herself was supposed to report to work for the day shift (7 am until 3 pm) and did not report to the facility until about 10 am, nor did she telephone the DoDS or QMRP to ask for additional support. The RD has been terminated as a result of substantiated verbal abuse and client neglect. The two staff people involved have been on administrative leave since the incident. The facility's investigation has cleared them due to findings during interview with the RD. The facility is awaiting the DDS ruling on if and when the staff can return to work. 2. It is not known how the client came to have access to plastic bags, nor is it known when (in terms of weeks to years) he had ingested the plastic. The physicians have not been able to report to the facility on how long the bags have been present in the client's body, only that they were "embedded" in flesh in the stomach. See response to W149. 3. See response to W158.	4-22-07 4-22-07

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/27/2007
FORM APPROVED
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	09G171	A. BUILDING _____ B. WING _____	03/14/2007

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CARECO 11	4501 GRANT STREET, NE WASHINGTON, DC 20019

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W 186	Continued From page 24 On February 28, 2007, at 9:00 a.m. Client #2 was observed sitting in the living room area with the direct care staff and his peers. Interview with the residential manager at 10:00 a.m. revealed that client #2 would not be attending his day program because he had a medical appointment. Further interview with the residential manager revealed that Client #2 had recent abdominal surgery. Interview with the Designated Nurse and the QMRP on the same day revealed that Client #2 went to have an esophogastroduodinoscopy (EGD) on an outpatient basis on January 24, 2007. A foreign body was observed in the stomach. In an attempt to remove the foreign body, the client aspirated. Client #2 was received emergency surgery to remove the foreign body. According to the operative report, twelve (12) plastic bags were removed from the clients stomach. Further interviews with the Designated Nurse and QMRP on March 3, 2007 at 3:00 p.m. and the on the same day revealed that it was not known how the client came to have access to the plastic bags. Interview with direct care staff #1 on March 5, 2006 revealed that Client #2 is capable of reaching for objects that he wants. He is also reportedly able to crawl on the floor. Review of the facility's internal investigation into this matter failed to evidence interviews and/or possible theories as to how the client came to have 12 plastic bags in his stomach. 3. The facility failed to ensure there were sufficient number of direct care staff to meet clients health care needs (missed appointments, court dates, etc) Interview with the designated nurse through out the entire survey process, revealed that several of	W 186		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/27/2007
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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W 186	Continued From page 25 the clients medical appointments as well as court and day program meeting dates had been missed due to insufficent staffing. Record reviews were conducted the Medical Records on March 2 and on March 3, 2007 for verification. Review of client #2's record evidence that he had not been able to complete audio, ENT and dental appointments.	W 186		
W 189	483.430(e)(1) STAFF TRAINING PROGRAM The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that each employee was provided with initial and continuing training that enabled the employee to perform his or her duties effectively, efficiently, and competently. The findings include: 1. The facility failed to ensure staff were effectively trained to maintain Client #3's privacy. (See W130) 2. The facility failed to ensure staff was trained on Client #1's diet texture requirements. [See W474] 3. The facility failed to ensure direct care staff had received training on how to handle "threats" at the work site. On March 12, 2007, the facility had identified and forwarded an incident report to the Department of	W 189	See response to W130. See response to W159 #9. See responses to W104, W122, W125, and W149.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/27/2007
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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W 189	Continued From page 26 Health , that alleged that client #4 had been subjected to verbal abuse by the facility's house manager, which was witnessed by the two employees involved in the March 7, 2007 incident. On March 13. 2006 at approximately 3:00 PM, client #4 was interviewed to verify if she had been verbally abused. client #4 revealed that she had been spoken too harshly by the house manager and was afraid of her. She further stated that she had been threaten with physical harm, if she said any thing to any one. On March 13, 2007 around 4:15 PM, staff were interviewed which verified the clients statement that the house manager had interacted inappropriately (verbally) with client #4. During the course of staff interviews, it was reported, that 3 additional clients that reside in this facility had also been subjected to inappropriate comments by the house manager. Staff stated that they knew that this was abuse and that it was wrong, however failed to report the abuse as indicated in the agencies policy and procedures. Each staff stated that their jobs had been threaten and felt that administration would not support them if they reported the abuse. Staff also stated that they had received recent training on abuse and neglect, client rights and incident reporting (February 24, 2007), stating that the abuse should have documented on an unusual incident report. Interviews conducted with the facility QMRP and administrator verified that the direct care staff had received training on reporting abuse and neglect. It was also stated that they recognized that the agency's policy and procedures were in need of revision, to include employee protection and reporting methods for employees who have witnessed abuse.	W 189		
W 193	483.430(e)(3) STAFF TRAINING PROGRAM	W 193	See responses to W122 and W130.	

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FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G171	A. BUILDING _____ B. WING _____	03/14/2007

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W 193	Continued From page 27 Staff must be able to demonstrate the skills and techniques necessary to administer interventions to manage the inappropriate behavior of clients. This STANDARD is not met as evidenced by: Based on observations, staff interviews and the review of records, the facility staff failed to demonstrate competency in implementation of Client #3's Behavior Support Plan (BSP). The findings include: Observations on February 28, 2007 at 3:00 PM Client #3 was observed sitting on the sofa in the living room area. Her assigned one to one staff (male) was standing by the sofa along with 3 of the client's housemates and 2 direct care staff. Client #3 was observed repeatedly to jump up quickly from the sofa and removing her shirt and pants. Staff responding immediately by redressing the Client. However the staff redressed her in the living room in the presence of housemates and other staff. Interview with the one to one staff revealed that "disorbing" was identified as one of the Client's target behaviors, which is addressed in a behavior support plan. It should also be noted that the Client was observed not wearing underwear. On March 1, 2007 at 7:15 AM, the Clients Habiliation Record were reviewed and a June 22, 2006 Behavior Support plan. The Plan included procedures on how to manage the client's disrobing behavior. The following steps were to be implemented: Staff should address	W 193		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/27/2007
FORM APPROVED
OMB NO. 0938-0391

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W 193	Continued From page 28 disrobing by keeping client engaged in a task as soon as possible. When the <client> begins to disrobe, staff should verbally direct her to stop. If disrobing continues, <client>, should be escorted to her bedroom or to the bathroom by female staff and verbally prompted to put her clothes back on. Out of four eposides observed, the staff only redirected Client #3 to the bathroom one time, which was done by a male staff.	W 193		
W 214	483.440(c)(3)(iii) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must identify the client's specific developmental and behavioral management needs. This STANDARD is not met as evidenced by: Based on staff interview and record review the facility failed to ensure that clients are provided assessments to support the proposed and implemented treatments for two of the four clients in the sample. (Clients #1, #2, and #3) The findings include: 1. During the medication administration conducted on February 28, 2007 at 6:00 AM client #1 received medications including Depakote, Seroquel and Buspar. According to the review of Client #1's medical record, the client has an AXIS I diagnoses which include Intermittent Explosive Disorder. Further review of the client's record revealed the aforementioned medications were used in conjunction with a Behavior Management Plan (BMP) to control maladaptive behaviors and anxiety. Review of the health recors and the ISP failed to evidence a comprehensive psychiatric assessment to support the Axis I diagnoses and appropriate treatment.	W 214	The QMRP will ensure that the clients with an Axis I diagnosis and recommendations have a comprehensive psychiatric review.	4-22-07

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FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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W 214	Continued From page 29 Interview was conducted with the Qualified Mental Retardation Professional on March 5, 2007 to ascertain if the client had a current psychiatric assessment. The QMRP indicated that she had been assessed however was unable to evidence. 2. During the medication administration conducted on February 28, 2007 at 6:00 AM client #2 received medications including Risperdal and Famotidine. According to the review of Client #2's medical record, the client has an AXIS I diagnoses which include Intermittent Explosive Disorder. Further review of the client's record revealed the aforementioned medications were used in conjunction with a Behavior Management Plan (BMP) to control maladaptive behaviors and anxiety. A review of the medical record evidenced monthly reviews of the medication and a 2003 psychiatric assessment, however it was missing pages, (incomplete report) and failed to evidence findings to support the AXIS I diagnoses and recommendations. Interview was conducted with the Qualified Mental Retardation Professional on March 5, 2007 to ascertain if the completed report could be obtained. At the time of the survey, the QMRP was unable to provide a completed report for review. 3. During the medication administration conducted on February 28, 2007 at 6:00 AM client #3 received the medication Zyprexa. According to the review of Client #3's medical record, the client has a AXIS I diagnoses which include Intermittent Explosive Disorder. Further review of the client's record revealed the aforementioned medications were used in conjunction with a	W 214		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
OMB NO. 0938-0391

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W 214	Continued From page 30 Behavior Management Plan (BMP) to control maladaptive behaviors. Monthly reviews of the medication was completed., however the habiliation record failed to evidence a comprehensive psychiatric assessment to support the Axis I diagnoses and appropriate treatment.	W 214		
W 249	483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on observations, interviews, and record verification, the facility failed to demonstrated that two out of four clients in the sample are actively and consistently encouraged to engage in learning opportunities to maintain or enhance their skill levels. (Clients #2 and #3) The findings include: 1. Observations on February 28, 2007 at 7:20 AM Client #3 was observed sitting on the sofa in the living room area. She was observed to jump up quickly, start laughing and dropped her pants to the floor. Staff were observed to pull her pants up and resit her on the sofa. At 7:35 AM, Client #3 was again observed to jump up from the sofa, and push her pants to the floor. At this time it was observed that she had no underwear on,	W 249	See responses to W130 and W159. Client #3's primary active treatment goals are encompassed in her BSP. The QMRP has ensured staff have been trained and retrained on the BSP, and will mentor and monitor staff to ensure the protocols are properly executed.	4-22-07

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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W 249	Continued From page 31 however staff still pulled her pants up and sat her back on the sofa. At 7:45 AM Client #3 was standing in front of the sofa with no pants on. Staff seated her on the sofa and preceded to dress her while sitting on the sofa. As staff tried to assist her, she attempted to bite the female staff on her breast. It should be noted that three other clients and 2 additional staff were observed in the den area at the aforementioned times indicated. During evening observation At 3:00 PM, Client #3 was observed sitting on the sofa again. Her assigned one to one staff (male) was standing by the sofa in the addition of three peers and two staff close by. Client #3 was observed repeatedly, to jump up quickly from the sofa and remove her shirt and her pants. Staff immediately redressed Client #3 however failed to ensure her right to privacy by redressing her in the living room. Interview with the one to one staff revealed that "disrobing" is identified as one of Client #3's target behaviors, which is addressed in a behavior support plan. It should also be noted that Client #3 was observed without underwear and a bra on. On March 1, 2007 at 7:15 AM, a review was conducted of the facility's Human Rights Committee minutes. On September 28, 2006, Client #3's June 22, 2006 behavior support plan had been reviewed and approved to include procedures on how to manage disrobing. The following steps were to be implemented: Staff should address disrobing by keeping client engaged in a task as soon as possible. When <client> begins to disrobe, staff should verbally direct her to stop. If disrobing continues, <client> should be escorted to her bedroom or to the	W 249		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/27/2007
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G171	A. BUILDING _____ B. WING _____	03/14/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARECO 11	4501 GRANT STREET, NE WASHINGTON, DC 20019

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W 249	Continued From page 32 bathroom by female staff and verbally prompted to put her cloths back on. There was no evidence that the QMRP was ensuring that staff implemented Client #3's behavior support as written. 2. On February 28, 2006, the house manager indicated that Client #2 was not attending his day program because he had recently had surgery and had not been cleared to go back. When he was cleared to return, a meeting had to be held prior to his return to the day program to discuss his needs and to determine if the day program was able to meet them. Observations on February 28-March 5, 2007, from 9:00 AM to 2:30 PM and again on March 13-14, 2007, 9:00 to 12:00 PM, Client #2 was observed in the living room most of the day with intermittent engagement from the staff. The staff was interviewed to ascertain information about an alternative activity schedule to be utilized during times when the client is at home. The staff indicated that no schedule had been developed, therefore no active treatment goals were being implemented.	W 249	The QMRP has developed an alternative schedule for times when clients are not in attendance at their normal day activities. The QMRP will develop a "sick day" schedule for clients who are at home due to medical reasons and need a very light or restful day.	4-22-07
W 250	483.440(d)(2) PROGRAM IMPLEMENTATION The facility must develop an active treatment schedule that outlines the current active treatment program and that is readily available for review by relevant staff. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility's QMRP failed to provide a	W 250	See response to W149.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/27/2007
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G171	A. BUILDING _____ B. WING _____	03/14/2007

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CARECO 11	4501 GRANT STREET, NE WASHINGTON, DC 20019

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W 250	Continued From page 33 schedule to include current active treatment programs for one of the four clients in the sample. [Client #] The finding includes: On February 28, 2006, the house manager indicated that Client #2 was not attending his day program because he had recently had surgery and had not been cleared to go back. When he was cleared to return, a meeting had to be held prior to his return to the day program to discuss his needs and to determine if the day program was able to meet them. Client #2 was observed in the living room most of the day with intermittent engagement from the staff. The staff was interviewed to ascertain information about an alternative activity schedule to be utilized during times when the client is at home. The staff indicated that no schedule had been developed nor were they implementing the client day program objectives.	W 250		
W 263	483.440(f)(3)(ii) PROGRAM MONITORING & CHANGE The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian. This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure that programs which incorporate restrictive techniques and the use of medications to control behaviors were conducted only with the written informed consent of the client or legal guardian for two of the four clients	W 263	See responses to W125 and W125	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/27/2007
FORM APPROVED
OMB NO. 0938-0391

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W 263	Continued From page 34 included in the sample. (Clients #1 and #3) The findings include: 1. Cross Refer to W124. There was no evidence that written informed consent had been obtained for restrictive intervention used as a part of a Behavior Support Plan to include 1:1 and psychotropic medications for Client #1. 3. Cross Refer to W124. There was no evidence that written informed consent had been obtained for restrictive intervention used as a part of a Behavior Support Plan to include 1:1 and psychotropic medications for Client #3.	W 263		
W 318	483.460 HEALTH CARE SERVICES The facility must ensure that specific health care services requirements are met. This CONDITION is not met as evidenced by: Based on observation, interviews, and record reviewed, the facility failed to establish systems to provide health care monitoring and identify services that would ensure health services were provided to meet the needs of the clients [Refer to W322]; failed to ensure that nursing services were provided in accordance with clients needs [Refer to W331]; failed to ensure timely dental services to meet the client's needs [See W356]; failed to ensure the facility's nurses have a policy/procedure to ensure quality control testing for the glucometer [See W393]; failed to ensure the pharmacist reviewed drug regiments at least quarterly [See W362]; failed to ensure that medications were administered in accordance to physician's orders. [See W368]; to ensure	W 318	The Director of Operations will revise the consultants' (pharmacy, et. al.) contracts to more specifically require timeliness of services The DON has developed current, updated HCMPs that have personalized, 24-hour medical shift logs to guide direct care staff in providing daily health supports and recording information for nursing review. A full time RN has been hired to report to the DON. The RN is experienced in providing services to the population, and will provide continual supervision and training to the facility DN, medication nurses and direct care staff. The DON provides supervision to the RN, DN and medication nurses, and provides weekly training as required on policy, medication administration, controlled substance storage and disposal, equipment use, and any other nursing issue that arises. The DON provided documentation on the new generation glucometer in use at the facility. The documentation outlines quality control testing and procedures for the glucometer. See responses to W120 #2 and W124.	4-22-07

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/27/2007
FORM APPROVED
OMB NO. 0938-0391

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W 318	Continued From page 35 medications are administered without error [See W369]; to maintain records of the receipt and disposition of controlled medications [See W385]. The effects of these systemic practices resulted in the demonstrated failure of the facility to provide health care services.	W 318		
W 322	483.460(a)(3) PHYSICIAN SERVICES The facility must provide or obtain preventive and general medical care. This STANDARD is not met as evidenced by: Based on interview, and record review the facility failed to have evidence that audiology, dental and ENT services were rendered to one of the four clients in the sample. (Client #2) The finding includes: 1. Review of the Audiology section of Client #2 ' medical record on March 2, 2007 at 10:00 a.m. revealed that the client had an audiology appointment on January 31, 2006. Review of the consultation sheet revealed that an examination could not be performed on the client due to his combativeness. The Audiologist recommended that the client return sedated for re-attempt at testing. The client had an appointment scheduled for May 1, 2006, however it could not be completed due to the client ' s refusal to leave the van. The audiologist recommended that the client be sedated for his next visit June 13, 2006. Further review of the audiology section of Client #2 ' s medical record failed to evidence that the client was evaluated on June 13th, however there was a consultation dated December 29, 2006,	W 322	See response to W120, W124, W159. The Nutritionist will provide additional clarification and training to facility staff on client #2's dining protocol. The PCP will review and approve the dining protocol and all swallow study reports. The QMRP will contact the audiologist to request a copy of the record for the client's last visit for evaluation/assessment.	4-22-07 4-22-07

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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W 322	Continued From page 36 that reveal the same documentation as January 31, 2006. Interview with the QMRP and Nurse on March 3, 2007, to ascertain when the clients hearing had been successfully evaluated, revealed that they could not provide the evidence. The LPN indicated that a previous administrator had p urged the chart of needed information. Interview with the QMRP on March 3, 2007, further revealed that Client #2 has a guardian for healthcare matters. There was no evidence that the guardian was notified of the problems in completing this evaluation. It should also be noted that review of the Human Rights committee meeting minutes for 2006, revealed that the use of sedation had been reviewed and approved for this evaluation. 2. Review of the ENT section of Client #2's medical record on March 2, 2007 at 8:45 a.m. revealed that the client had an ENT appointment scheduled for March 15, 2005. Although the consult indicated that the client was agitated and uncooperative, it was documented that the client's ears " appeared to have cerumen in bilateral canals." Colace eardrops was prescribed. There was no documented evidence that the client returned to assess the effectiveness of the drops. The next ENT appointment was seventeen months later August 7, 2006, which indicated that Client #2 was not cooperative; and recommended that the client return sedated. An October 2, 2006 consultation indicated that the client arrived 11/2 hour late for his appointment and was not sedated. Again a recommendation was made for the client to return sedated. On December 8, 2006, the client could not be evaluated and a recommendation for the client to return sedated	W 322	The QMRP will coordinate with the client's guardian and the human rights committee for sedation, and the QMRP will coordinate with the ENT's office and the DN to set an appointment and ensure that the client is sedated before attempting the appointment.	4-22-07

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/27/2007
FORM APPROVED
OMB NO. 0938-0391

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W 322	Continued From page 37 was noted. Interview with the QMRP on March 3, 2007, further revealed that Client #2 has a guardian for healthcare matters. There was no evidence that the guardian was notified by the QMRP of the identified problems in completing this evaluation. It should also be noted that review of the Human Rights committee meeting minutes for 2006, revealed that the use of sedation had been reviewed and approved for this evaluation. 3. The facility failed to ensure clients receive liquids as recommended to prevent aspiration as evidenced below: On February 28, 2007, at 4:15 p.m. Client #2 was observed receiving water in the livingroom area. The fluid was thickened and presented to the client in a regular cup. The client was observed to cough intermittently while receiving the liquid. Interview with the Qualified Mental retardation Professional (QMRP) on March 2, 2007 at 2:00 PM revealed that the client was on a "chopped with ground meats" diet until he received a Swallow Study on January 4, 2007, which revealed that the Client had 'moderately severe oropharyngeal dysphagia. The safe food textures recommended was creamy or thick pureed. and the safe liquid consistencies was honey. The swallow function report also indicated that the liquids should be given by spoon only. The QMRP nor the nurse could explain why the client did not receive his liquids via spoon as recommended by the Speech and Language Pathology report. It should be noted that there was no evidence that the Primary Care Physician	W 322	The QMRP has ensured that all staff have been trained on dining protocols for the client; the DoDS has demonstrated the protocol and mentored individual staff to ensure that the client can eat and drink safely.	4-22-07

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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W 322	Continued From page 38 had reviewed the report.	W 322		
W 331	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by: Based on observation interview and record review the facility failed to ensure the nursing services had policy's and procedures to ensure quality control testing for the use of glucometers for one of one client in the sample requiring finger sticks, (Client #1), failed to ensure timely completion of medical appointments for one of four clients in the sample (Client's #2), and failed to ensure Client #5's medical needs were met timely. The findings include: 1. The nursing staff failed to ensure the timely completion of medical appointments as evidenced below: Cross refer to W322. The nursing staff failed to ensure the timely completion of audiology appointments (W322.1) ENT appointments (W322.2) and Dental appointments (W322.3) Interview with the facility's nurse and QMRP on March 3, 2007, at 2:30 p.m. revealed that Client #2's behavior support plan indicated that after three failed attempts at an appointment, the client could be sedated, however, the nurse nor the QMRP could verify when (historically) Client #2 had successfully completed the aforementioned appointments. It could not be determined if the Client #2's Audiologic, ENT or Dental status had changed or remained the same as no historical	W 331	See responses to W120 #2 and W318. The QMRP and DoDS met with the Psychologist to determine the meaning of "3 failed attempts." The Psychologist discussed the need for sedation or desensitization so that the client's health care needs can be managed timely. The scenario of failed attempts was a portion of the desensitization protocol, and had been misinterpreted. The Psychologist revised the BSP and provided training to the staff and the QMRP.	4-22-07

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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W 331	Continued From page 39 data was available for review. 3. The nursing staff failed to ensure Client #2 received water via spoon as recommended by the speech therapists evidenced by the following: On February 28, 2007, at 4:15 p.m. Client #2 was observed receiving water in the livingroom area. The fluid was thickened and presented to the client in a regular cup. The client was observed to cough intermittently while receiving the liquid. Interview with the Qualified Mental retardation Professional (QMRP) on March 2, 2007 at 2:00 PM revealed that the client was on a "chopped with ground meats" diet until he received a Swallow Study on January 4, 2007, which revealed that the Client had 'moderately severe oropharyngeal dysphagia. The safe food textures recommended was creamy or thick pureed and the safe liquid consistencies was honey. The swallow function report also indicated that the liquids should be given by spoon only. The QMRP nor the nurse could explain why the client did not receive his liquids via spoon as recommended by the Speech and Language Pathology report. It should be noted that there was no evidence that the Primary Care Physician had reviewed the report. There was also no evidence that the nursing staff clarified the need to have the liquids served via spoon. 4. The nursing staff failed to verify how much thickener was needed for each type of liquid to ensure the proper consistency as evidenced below:	W 331	See response to 159 #9. See response above.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
OMB NO. 0938-0391

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W 331	Continued From page 40 Observations at the group home on March 14, 2007, at 11:30 a.m. revealed the nurse and the Administrator preparing to give Client #2 a can of Ensure Plus. The nurse placed 2 scoops of thickener in the cup, the Administrator stirred the liquid and, as it was not the right consistency, requested that more thickener be placed in the cup. It was evident that no clear guidelines were given to the facility as to the proper amount of thickener to use to ensure a honey thick consistency for the ensure. Interview with the Administrator and the nurse acknowledged the need for clarification and further guidance from the nutritionist. 5. Interview conducted with the House Manager on February 28, 2007, revealed that Client #5 was receiving medical oversite from a different Primary Care Physician, than the other six clients in the facility. Client #5's sister, who is her health care guardian (limited) reportedly, in August, 2006, terminated the client's health care services provided by the facility's PCP. The client's sister identified another physician to provide health care services. The facility staff however, voiced ongoing concerns that communication with the new PCP had been essentially non-existant. On the day of the revisit, the direct care staff went to the PCP's medical office to drop off several speciality consults documents and physican order sheets for signature and review. The staff returned and stated that the receptionist told them it could take up to 10 working days for the PCP to review, sign off and to make recommendations if warranted. The staff returned to the facility with no documents or evidence of the visit. On March 1, 2007 three sheets and forms were	W 331	See response to W104	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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OMB NO. 0938-0391

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W 331	Continued From page 41 observed in the front pocket of Client #5's Medical Book. A notation was written on the side "Sent to Dr. < > on 3/1/07 for review.(GYN-10/9/06, PT-11/15/06, and Orthopedic-1/31/07). To date, there was no evidence that the facility's new Director of Nursing had met with Client #5's new primary care physican to establish a relationship, to establish a clear line of communication, to ensure timely visits and assessments, to ensure timely review of outside specialist reports and recommendations and to order medications when changes were warranted, timely.	W 331		
W 356	483.460(g)(2) COMPREHENSIVE DENTAL TREATMENT The facility must ensure comprehensive dental treatment services that include dental care needed for relief of pain and infections, restoration of teeth, and maintenance of dental health. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure clients receive timely dental care for one of the four clients in the sample. (Client #2) The finding includes: On March 2, 2007, Client #2 was observed receiving his lunch. The lunch was pureed by the staff. The client's teeth could not be observed during the feeding. The direct care staff was asked if he had teeth on March 2, 2006. The direct care staff replied yes. Review of the dental section of Client #2 ' s medical record on March 2, 2007 at 10:45 a.m. revealed a consultation dated July 20, 2006 that indicated services were	W 356	See response to W120 #2.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
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CARECO 11	4501 GRANT STREET, NE WASHINGTON, DC 20019

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W 356	Continued From page 42 not rendered secondary to the pre-authorization expiration. On November 21, 2006, the consultation indicated that the client was not seen. Although there was no reason was indicated, there was a recommendation to " please sedate. " On January 18, 2007, the dental consultation report indicated that it was a re-call examination. The client had " moderate calculus deposits . . . patient needs scaling . . . will submit pre-authorization. " Interview with the QMRP and the House manager on March 2, 2007, revealed that they rely on the physician's office to call and let them know when the office received the authorization. The QMRP acknowledged the need for a better system to ensure dental appointments were completed timely. There was no evidence that that the QMRP had taken the necessary steps to ensure that Client #2's dental services were being met.	W 356		
W 362	483.460(j)(1) DRUG REGIMEN REVIEW **A pharmacist with input from the interdisciplinary team must review the drug regimen of each client at least quarterly.** **This STANDARD is not met as evidenced by:** Based on interview with the supervisory nurse and record verification, the facility failed to ensure that quarterly drug reviews were conducted timely for one of the four clients in the sample. (Client #4). The findings include: Interview with the nurse revealed that the	W 362	ee response to W318. The QMRP will ensure the Pharmacist receives timely reminders of when reviews are due.	4/22/07

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
OMB NO. 0938-0391

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W 369	Continued From page 44 This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure medications were administered without error for one of the seven clients observed receiving medications. (Client #6) The finding includes: During the medication pass observation on February 28, 2007, Client #6 was observed receiving Prednisolone AC eye drops, Neo/poly ointment to her left eye lid, multi-vitamins, Keppra, Paxil, Zyrtec, Risperdal and Constilose. review of the medication administration record and the physician orders on the same day at 8:00AM, revealed that the client should have received Nasacort nasal spray to each nostril. The observation was relayed to the Designated Nurse. The facility failed to administer medications without error.	W 369	The DON tracks medication administration, appointments and other nursing/medical issues weekly. This information is used to provide continual training to nurses and staff, and to track client health needs.	4/22/07
W 385	483.460(l)(3) DRUG STORAGE AND RECORDKEEPING The facility must maintain records of the receipt and disposition of all controlled drugs. This STANDARD is not met as evidenced by: Based on observation, staff interview, and record verification, the facility failed to maintain records of the receipt and disposition of all controlled drugs for one of the three clients residing in the sample. (Client #4). The finding includes:	W 385	See response to W318. The DON will provide continuous training on medication administration and weekly review of medication administration.	4/22/07

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FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G171	A. BUILDING _____ B. WING _____	03/14/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARECO 11	4501 GRANT STREET, NE WASHINGTON, DC 20019

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W 362	Continued From page 43 pharmacist conducts quarterly drug reviews. Record verification on March 1, 2007 at 8:05 AM revealed no drug regimen review was conducted for Client #4 between October 11, 2006 and March 1, 2007. There was no evidence that the drug reviews were conducted at least quarterly.	W 362		
W 368	483.460(k)(1) DRUG ADMINISTRATION The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to administer medications in accordance with the physician's orders for one of seven clients observed receiving medications. (Client #6) The finding includes: During the medication pass observation on February 28, 2007, Client #6 was observed receiving Prednisolone AC eye drops, Neo/poly ointment to her left eye lid, multi-vitamins, Keppra, Paxil, Zyrtec, Risperdal and Constilose. Review of the medication administration record and the physician orders on the same day at 8:00 AM for verification, revealed that the client should have received Nasacort nasal spray to each nostril. The observation was relayed to the Designated Nurse. The facility failed to administer medications as prescribed.	W 368	The facility has hired a full time RN Supervisor to report to the Director of Nursing. The RN Supervisor will provide continual supervision and training to the facility DN, Medication Nurses and Direct Care Staff. The DON provides weekly training as required on policy, medication administration, and any other nursing issues that arises. The DON submits a weekly nursing report to the governing body.	4-22-07
W 369	483.460(k)(2) DRUG ADMINISTRATION The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error.	W 369		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/27/2007
FORM APPROVED
OMB NO. 0938-0391

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W 369	Continued From page 44 This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure medications were administered without error for one of the seven clients observed receiving medications. (Client #6) The finding includes: During the medication pass observation on February 28, 2007, Client #6 was observed receiving Prednisolone AC eye drops, Neo/poly ointment to her left eye lid, multi-vitamins, Keppra, Paxil, Zyrtec, Risperdal and Constilose, review of the medication administration record and the physician orders on the same day at 8:00AM, revealed that the client should have received Nasacort nasal spray to each nostril. The observation was relayed to the Designated Nurse. The facility failed to administer medications without error.	W 369		
W 385	483.460(l)(3) DRUG STORAGE AND RECORDKEEPING The facility must maintain records of the receipt and disposition of all controlled drugs. This STANDARD is not met as evidenced by: Based on observation, staff interview, and record verification, the facility failed to maintain records of the receipt and disposition of all controlled drugs for one of the three clients residing in the sample. (Client #4). The finding includes:	W 385	The QMRP will request the DCHRP to complete a training on the receipt and disposition of Schedule IV drugs.	4/22/07

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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W 385	Continued From page 45 The facility failed to provide evidence of the disposition of the Controlled Schedule IV Drug (phenobarbital) prescribed for Client #4 as evidenced by: Observation of the medication pass on February 28, 2007 at 6:00 a.m. revealed that the Licensed Practical Nurse (LPN) administered Phenobarbital 30mg by mouth to Client #4. Review of the Medication Administration Record (MAR) and the physician orders revealed that Client # 4 was ordered the medication for seizure management. Interview with the Designated LPN revealed that that the facility does maintain a separate record of the receipt or disposition for the Controlled Schedule IV Drugs, that they were told by the pharmacy that they only had to have a record for the Schedule II drugs. There was no evidence that the facility had a system to record the receipt, disposition and monitoring of the receipt or disposition for the Controlled Schedule IV Drugs as required by federal regulations and the Comprehensive Drug Abuse Prevention and Control Act of 1970, 21 U.S.C. 801 et seq., as implemented by 21 CFR Part 308.	W 385		
W 393	483.460(n)(1) LABORATORY SERVICES If a facility chooses to provide laboratory services, the laboratory must meet the requirements specified in part 493 of this chapter. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure it met the requirements for performing glucose monitoring testing for one of one clients who requires glucose testing. (Client #1)	W 393	The facility will apply for the certificate of waiver as required by the Clinical Laboratory Improvement Act. The DON has provided the facility with a new glucometer and manages all control testing issues per the manufacturer. The documentation on this equipment has been submitted to HRA as part of a previous survey response.	4/22/07

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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W 393	Continued From page 46 The finding includes: During the morning medication administration observation on February 28, 2007 and the evening of March 1, 2007 at 4:30 p.m. the nurse was observed performing a fingerstick glucose test on client #1. . During the medication pass observation on March 1, 2007 at 4:10 p.m. the nurse was observed performing a blood glucose measurement utilizing an glucometer.Interview and record verification on March 1, 2007, revealed that Client #1 is diabetic and requires insulin twice a day. Client #1 is also prescibed 4GMs of glucose by mouth for readings of 60 or less. Interview with the facility's Designated Nurse on the same day to ascertain what procedures were in place to ensure quality control of the glucometer, she indicated that there was no policy/procedure in place and that she takes it upon herself to perform the testing on the machine. When asked if there was documentation to support her statement, she indicated that she does not document the results anywhere. Further review of the clients medical record in the old Medication Administration Records section revealed that the client received Glucose 4 GMs for finger stick readings of 60 and below on the following occasions: June 2006, she received the glucose two times; August 2006 she received the glucose three times; October 2006, she received the glucose six times; November 2006, she received the Glucose two times; and February 2007 she received the Glucose one time. Review of the manufactures manual for the	W 393		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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W 393	Continued From page 47 glucometer revealed the recommendation to perform control testing on the machine. Interview with the designated nurse on March 1, 2007, at 2:00 p.m. revealed that the provider does not have a certificate of waiver as required by part 493 of the Clinical Laboratory Improvement Act (CLIA). It should be noted that this matter was referred to the laboratory surveyor for review on March 2, 2007 at 10:00 a.m.	W 393		
W 436	483.470(g)(2) SPACE AND EQUIPMENT The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. This STANDARD is not met as evidenced by: Based on observation, interview and record review the facility failed to have available adequate amounts of adaptive equipment and to ensure that adaptive equipment is maintained for two of the four clients in the sample (Clients #2 and #3) The findings include: The facility's Qualified Mental Retardation Professional failed to ensure that all adaptive equipment was obtained timely as recommended and maintained as evidence below: 1. On February 28, 2007, Client #2 was observed ambulating with a roller walker and the assistance	W 436	The rubber tips for the back legs of the walker will be replaced.	4/22/07

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W 436	Continued From page 48 of staff. The walker was scraping the floor. Further inspection of the walker revealed that the back legs was missing the rubber tips. Interviews with the house manager and the Qualified Mental Retardation Professional revealed that they acknowledged the lack of rubber tips to the walker. 2. During the morning observation on February 28, 2007 at 7:35 AM, staff were observed asking each client if they would like a cup of water. Client #4 requested at that time if she could have something to drink. It was noted that all of her peers were drinking at the time. The direct care staff told her that she would have to wait for something to drink because her adaptive cup was in the dishwasher and the dishwasher was already running. At 8:00 AM and at 8:10 AM, Client #4 asked again for something to drink, however, prior to her leaving the facility for her day program, she was not observed receiving anything to drink as requested. Interview with the staff and the QMRP revealed that Client #4 only had one adaptive cup in the facility to use. 3. On February 28, 2007 at 8:00 AM, Client #4 was observed sitting in her wheelchair. Her feet were observed to be extending beyond the tops of her foot rest and her body was observed extended out from her seating mechanism. She was heard telling staff that she was uncomfortable and needed to be adjusted in her wheelchair. As staff was attempting to re-adjust client #4's wheelchair, by lowering the tilting mechanism, the staff had difficulty manipulating the tilt lever. The staff stated that her wheelchair was in need of repairs. During program observation at the day program	W 436	Additional "sippy" cups will be purchased. Client #4's new wheelchair has been delivered. The PT has trained her and staff on its use.	4/22/07

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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W 436	Continued From page 49 later that morning, Client #4's feet were observed again hanging over the top part of the foot rest. Client #4 expressed discomfort while sitting in her wheelchair and asked if staff could readjust her. The Day program staff reported that Client #4's wheelchair did not properly fit to accommodate her body needs, and had been in need of replacement for some time. Interview later that afternoon with the QMRP and the House manager revealed that a new wheelchair has been on order for "some time." The requisition to order the chair, (719A) had been completed and measurements for the chair had been taken in February 2007, and a consult for a fitting had just occurred recently. The house manager produced documentation which indicated that the wheelchair process had been comleted in June 2006 (8 months ago). Review of the agencies "Adaptive Equipment Acquisition, Replacement, Modification and Repair policy", the entire process from the beginning to end should be completed within a 60 day period from the the date the need is determined. According to the physical therapy assessment dated April 7, 2006, it was determined that Client #4 needed a new wheelchair. It further states "when there are delays in the acquisition of the equipment within 60 days, the QMRP of Case Manager will notify the Clinical Services at the [government monitoring agency.]" The identified interim plan will also be documented and this written notice will be filed int he customers record. There was no evidence of an interim plan to provide comfort to the client while in the wheelchair. 4. According to Client #4's ISP, she is to wear Swanson cones daily in each hand daily. At no time during the entire survey process did the	W 436	The QMRP will request the PT to re-assess the need for the Swanson cones and provide staff training if they are recommended.	4/22/07

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W 436	Continued From page 50 QMRP ensure that Client #4 was offered the cones or observed to wear them as indicated. 5. During the environment observation it was observed that Client #7's wheelchair was in need of repairs. Both arm rest were torn and the wheels evidenced wear and tear.	W 436		
W 448	483.470(i)(2)(iv) EVACUATION DRILLS The facility must investigate all problems with evacuation drills, including accidents. This STANDARD is not met as evidenced by: Based on interview and record verification, the facility failed to address problems which occurred when evacuation drills were held. The finding includes: On March 1, 2007, at approximately 740 AM, review of the facility ' s fire drill evacuation records for the period 4/7/06 - to present, there were four fire drills (4/25/06, 5/26/06, 7/10/06, 7/26/06 that identified three clients(#3, #5 and #6 as combative, non-compliant and resistive to staff interventions during the fire drill. Further review of the fire drill reports revealed that the House Manager (HM) and the Qualified Mental Retardation Professional (QMRP) are responsible for monitoring, reviewing, identifying problems and signing off on the fire form after every fire evacuation drill. The aforementioned months failed to reflect that neither the HM nor the QMRP reviewed, signed off and were made aware of the potential safety risk from these clients refusal to leave the facility during these fire drills. There was no evidence that the facility	W 448	The QMRP and the DoDS will train the new Residential Director on fire drill evacuation procedures, document client behaviors during the drill, and plan programming to assist the clients to be cooperative during such drills.	4/22/07

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W 448	Continued From page 51 investigated to see why the clients refused to move during the evacuation drill.	W 448		
W 474	483.480(b)(2)(iii) MEAL SERVICES Food must be served in a form consistent with the developmental level of the client. This STANDARD is not met as evidenced by: Based on observation, staff interviews and record review, the facility failed to serve foods in a form consistent with dietary orders for one of the four clients in the sample (Clients #1) The findings include: The facility failed to ensure that Client #1 received food in a form consistent with their prescribed dietary needs as evidenced below: On March 14, 2007 at 2:00 p.m. Client #1 returned to the facility with her 1:1 staff. Client #1 was observed with a toy from a restaurant. Interview with the staff revealed that the client ate lunch at a resturant. The staff indicated that the client ate chicken nuggets and french fries and a diet soft drink. When asked how the food was served to the client the staff indicated they were given in the form they are sold in the store. Interview with the administrator and the nurse on the same day acknowledged that Client #1 was prescribed a chopped (dime size) 1500 calorie, low sodium diet. Further interview with the staff revealed that he was not aware of any special diet or texture requirement for Client #1.	W 474	/the QMRP will ensure that the Registered Dietician reviews and updates client dietary plans, the PCP will review and approve the plans, and the Dietician will provide training to all staff.	4/22/07
W 484	483.480(d)(3) DINING AREAS AND SERVICE The facility must equip areas with tables, chairs, eating utensils, and dishes designed to meet the	W 484	The QMRP will review all dining needs and ensure that appropriate equipment in proper quantity is in place at the facility.	4/22/07

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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W 484	Continued From page 52 developmental needs of each client. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure adequate numbers of adaptive drinking devices was available to meet the needs of one of the four clients in the sample. (Client #4) The finding includes: On February 28, 2007 at 7:35 AM, the direct care staff was observed asking each client if they would like a cup of water. Client #4 requested at that time if she could have something to drink. It was noted that all of her peers were drinking at the time. The direct care staff told her that she would have to wait for something to drink because her adaptive cup was in the dishwasher and the dishwasher was already running. At 8:00 AM and at 8:10 AM, Client #4 asked for something to drink, however, prior to her leaving the facility for her day program, she was not receive anything to drink as requested.	W 484		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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{W 000}	INITIAL COMMENTS On February 28, 2007 thru March 1,2007, a follow-up survey was conducted to verify compliance with the Conditions of Health Care Services previously determined to not be in compliance on January 22, 2007. One Client was included as a focus. (Client #2) The findings of the survey were based on observations at the group home and interviews with staff and clients, and the review of records including incident reports and Administrative records. Although the facility made some progress, it was determined that the Conditions of Participation in Health Care Services had not been met.	{W 000}	The focus client for the survey was atypical in that her medical guardian chose to switch the client's care to a clinical team not associated with the facility. The Governing Body requested DDS to relocate the client prior to the switch being made, but as no provider had availability to accept the client she remained in the facility. When HRA cited the facility for being out of compliance with a Condition of Participation, DDS arranged for the client to be accepted elsewhere prior to the facility losing its certification.	
W 104	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Based on observations, interviews and the review of records, the facility's Governing Body failed to provide general operating direction over the facility. The findings include: 1. Cross refer to W120. The Governing Body failed to obtain an outside contract with Client #2's designated Primary care physician to ensure her health care needs were met timely.	W 104	The Governing Body has contacted the PCP for client #2 face-to-face, in writing, and via telephone to explain the need for a contract in accordance with federal regulations governing ICFs/MR. On April 6, 2007 the PCP signed the contract, however the other required documents have not been provided to the facility, though requested. These documents include proof of insurance and a health certificate. The QMRP and the Director of Disability Services have coordinated a meeting with the client's medical guardian, staff from DDS, and staff from another provider who has agreed to provide residential services to her first in respite care, and then, when available, a different residence funded under the HCB Waiver. The client will be discharged from the facility and will have moved to the respite facility by [redacted]	4/13/07
{W 125}	483.420(a)(3) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage	{W 125}	The facility policy is that the QMRP will, for all clients in need of a legal decision maker, submit requests and documentation of the need to DDS for legal processing. The QMRP has submitted such requests for all clients remaining in the facility who are in need of this legal protection.	4/22/07

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Marsha H. Simpson — TITLE: Director of Disability Services — (X6) DATE: 4/10/07

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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CARECO 11	4501 GRANT STREET, NE WASHINGTON, DC 20019

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{W 125}	Continued From page 1 individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process. This STANDARD is not met as evidenced by: Based on staff interview, and record review, the facility failed to establish a system that would ensure that clients identified as unable to protect their own rights were assessed and provided established and legally sanctioned avenues to protect their rights for one of the one clients included in the investigation. (Client #1) The finding includes: Interview with the Residential Director/Acting QMRP on January 18, 2007, revealed that Client #1's had a sister who was involved in her life, but was not her legal guardian. During a recent hospitalization from September 26-October 12, 2006 the Dept on Disablity Services (DDS) case manager and Client #1's attorney informed the QMRP, that the sister no longer wanted to be involved with the client and advised the QMRP that any matters that needed to be handled, be done through the client's attorney. Review of Client #1's record during another hospitalization from October 25-November 7, 2006 revealed that on November 3, 2006, the hospital staff suggested to Client #1's primary care physician (PCP), that a"Do Not Rescistate" (DNR) needed to be established, due to the client's fragile state. Reportedly, the DDS case manager informed the hospital that since Client #1 was an DDS client, a DNR order could not be done. The hospital noted that a phone call was	{W 126}		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/26/2007
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G171	A. BUILDING _____ B. WING _____	R-C 03/01/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARECO 11	4501 GRANT STREET, NE WASHINGTON, DC 20019

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{W 125}	Continued From page 2 made to client #1's sister to discuss this matter , however the sister was not available. On November 4, 2006, the hospital noted that contact was attempted again about the code status. They were still unable to contact the sisiter. The hospital noted that the PCP stated that he was unaware of Client #1's family involvement, however indicated that Client #1 could be made DNR by family, guardian or courts, that a DNR could not be made by the physician. The physician did indicated that he would agree with DNR status if her sister concurs and signed the release. Although the DNR was not established at that time, Client #1's health improved to where she was discharged back to the group home in good status. Review of Client #1's psychological assessment dated June 26, 2006, Client #1 does not evidence the capacity to make independent decisions on her behalf regarding her habilitation planning, treatment, placement, financial, and medical matters due to profound mental retardation. According to the Residential Director, the QMRP had requested that the Case Manager to start the process immediately to purse guardianship for Client #1, however there was no evidence in the record to determine that the facility had established a system to ensure that legally sanctioned advocacy was made available for clients identified as incapable of comprehending their treatments and the risk and benefits associated.	{W 125}		
{W 149}	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written	{W 149}	The DoDS submitted the facility healthcare policies to the DCHRP for review and comment. The Director of the DCHRP will return comments to assist the facility in achieving basic assurances in healthcare services.	4/26/07

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
OMB NO. 0938-0391

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	09G171	A. BUILDING _____ B. WING _____	R-C 03/01/2007

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{W 149}	Continued From page 3 policies and procedures that prohibit mistreatment, neglect or abuse of the client. This STANDARD is not met as evidenced by: Based on staff interview and the record verificationduring the revisit ending February 28, 2007, the facility failed to implement its policies to manage the health care needs for all the clients that reside in this facility. The findings include: According to the facility's 2/12/07 Plan of Correction, the Director of Disability Services (DoDS) would coordinate by February 27, 2007, with the Director of Nursing (DON), the QMRP and outside supports such as the Health Resources Partnership to develop written health policies, procedures and protocols and train/mentor all facility staff to implment them. The DoDS would also perform weekly quality assurance checks, and the agency's Quality Assurance Department would provide monthly monitoring to ensure that staff are well versed in all procedures and are implimenting and documenting them as required. At the time of the revisit, the facility was unable to provide evidence that health policies, procedures and protocols had been developed and that weekly quality assurance checks had been implemented. According to the facility's Designated Nurse, the health care policy and procedures were in the revision process.	{W 149}		
{W 159}	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a	{W 159}	The QMRP and DON have and will continue to provide training to facility staff on each client's health care needs based upon current HCMPs and the accompanying, individualized 24-hour medical shift log. See response to W318 and W322.	4/22/07

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/26/2007
FORM APPROVED
OMB NO. 0938-0391

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	09G171	A. BUILDING _____ B. WING _____	R-C 03/01/2007

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{W 159}	Continued From page 4 qualified mental retardation professional. This STANDARD is not met as evidenced by: Based on interview, and record review, the Qualified Mental Retardation Professional (QMRP) failed to ensure the coordination of services for Client #1. The findings include: 1. Cross refer to W192. The QMRP failed to coordinate with nursing staff to ensure that nursing services were provided in accordance with the needs Client #1. 2. Interview with Client #1's one to one staff on the weekend of November 25, 2006 through November, 2006, revealed that he had worked a 24 hours shift. The employee indicated that on November 25 and 26th, 2006, he was responsible for all of Client #1's care to include all ADL's feeding, drinking, changing, repositioning and active treatment. On November 25, 2006, Client #1's health status had changed and was requiring closer supervision due to lethargy, refusal to eat and drink. He indicated that he did take a hour break from providing services, because he needed to sleep a little. There was no evidence that the QMRP had ensured that adequate staffing and oversight of Client #1's needs were being met. 3. Cross refer to W192. The QMRP failed to ensure that the health care guidelines established for Client #1, were available for staff review at all times. Review of the facility's training records evidenced	{W 159}	1. The Program Director, Registered Nurse, and Assistant QMRP/Residential Director who were directly responsible for the day-to-day care of Client #1 are no longer employed by the facility. The QMRP and the new Director of Nursing (DON) are coordinating care through ensuring that each client's health care management plan is updated timely and comprehensively, that staff are trained when changes take place, and that both staff and the Designated Nurse make daily use of the 24-hour medical shift log. 2. The DoDS has completed recruit actions to ensure the facility has adequate staff, and that staff are assigned to work reasonable hours as provided by law. 3. The QMRP and DON have trained staff on health care guidelines for clients served in the facility, and have made them available for staff review at all times. The 24-hour medical shift log provides specific directives for staff to support clients' health care needs.	4/22/07 4/22/07 4/22/07

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/26/2007
FORM APPROVED
OMB NO. 0938-0391

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{W 159}	Continued From page 5 that the staff had received training on 3/29/06 on Client #1's care. The training stated in order to support Client #1's current medical status the staff were to do the following: a. Offer Client #1 something to drink every hour. She should have a total of at least 8 glasses of fluid a day. If she goes over 4 hours without taking in any fluids, contact the designated nurse. b. If Client #1 does not consume at least 3/4 of each meal/snack offered to her, offer her something different that is in her diet plan. Notify the designated nurse if after 3 attempts at that meal/snack time she still does note eat at least 3/4's of foods (remember you are giving her other options if she refuses the food choice). c. Notify the Designated nurse if there is any change in her level of activity. d. If there is no bowel movement in 2 days, inform both the medication nurse and the designated nurse. Although this training had occurred on this protocol, there was not evidence that this protocol was a part of the of the direct care staffs' documentation record, "health monitoring book". It should also be noted that Client #1's one to one assigned staff was new to the facility (October, 2006) had not received training on this protocol.	{W 159}		
{W 318}	483.460 HEALTH CARE SERVICES The facility must ensure that specific health care services requirements are met.	{W 318}	A full time RN who has documented experience successfully serving the population has been hired to report to the DON, supervise the DN and ensure continual training and implementation of health care supports for each client, and to provide current training on signs and symptoms of illness.	4/22/07

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
OMB NO. 0938-0391

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	09G171	A. BUILDING _____ B. WING _____	R-C 03/01/2007

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{W 318}	Continued From page 6 This CONDITION is not met as evidenced by: Based on observation, interviews, and record reviewed, the facility failed to establish systems to provide health care monitoring and identify services that would ensure nursing services were provided in accordance with clients needs [See W331]; failed to ensure health services were provided to meet the needs of the clients [See W322]; the facility's nursing services failed to ensure that all staff working with the clients has been trained on the signs and symptoms of illness. The results of these systemic practices results in the demonstrated failure of the facility to provide health care services.	{W 318}		
{[redacted]22}	483.460(a)(3) PHYSICIAN SERVICES The facility must provide or obtain preventive and general medical care. This STANDARD is not met as evidenced by: Based on observation, staff interview, and record verification during the re-visit ending February 28, 2007, the facility failed to provide preventive and general care for one of the one clients in the sample. (Client #2). The findings include: According to the facility's 2/12/07 Plan of Correction, the Director of Nursing (DON) would coordinate with the Director of Disablity Services (DoDS) to develop and implement a 24-hour "medical shift log". It would be individualized per client; would required staff and nursing to check health status; provide instructions for care; and	{W 322}	The DON met with the Designated Nurse and the QMRP. The DON explained the expected review and sign-off protocol to the DN and QMRP. The DN reviews and signs each shift log daily so that should health care concerns arise they can be quickly noted and addressed.	4/22/07

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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	09G171	A. BUILDING _____ B. WING _____	R-C 03/01/2007

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{W 322}	Continued From page 7 track food and fluid intake, elimation, seizures, etc. On each day there should be evidence of nursing communication to staff as well as to other health care professional as needed to ensure that both routine and critical infromation on health status was thoroughly reviewed timely, and for appropriate action be taken. A review of each clients Health Program Record was completed on February 28, 2007 for verification. The records revealed that a shift log was in each client's record. Record verification evidenced direct care staff documentating daily and leaving notes for the nursing staff. However, there was no evidence at the time of verification, that any nurse had reviewed the medical shift log daily. Interview later that day with the Director of Nursing revealed that the expectations of the nurses were to reveiw the shift logs daily and document that it was reviewed with recommendations if warranted. However when a log was presented to the the Director of Nursing for her review, there was no evidence that a nurse had reviewed and or documented on this form daily as required by Policy and Protocol. The DON was unable to determine who or when and if the shift log had been reviewed. She indicated that further training with the nursing staff was warranted to ensure proper health care prevention.	{W 322}	The facility has hired a full time RN supervisor to report to the DON, and oversee the DNs, medication nurses, and facility staff in the provision of health care supports. The RN supervisor and the DON will provide formalized training on the signs and symptoms of illness to all facility staff, and will also provide individualized training and mentoring to strengthen staff skills. The DON has established a system of health care monitoring and review and communication of health issues between staff and nursing, and nurse-to-nurse. This system ensures that health services are provided to meet the needs of the clients. The DON has established a protocol for the staff to daily complete 24-hour personalized medical shift logs and for nursing to review and sign each day. The DON also reviews weekly medical appointments and medication administration, and provides a report on any problems or issues to the DoDS and the Director of Operations. She uses this data to provide immediate training to nursing and staff. The DON has established monthly grand rounds where client health care needs and services to be provided are discussed, agreed upon, scheduled and staffed. The DN nurse and the new RN will attend the grand rounds with the QMRP and direct care staff (where feasible and desireable).	4/22/07
{W 331}	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by: Based on interview and record verification and findings at the revisit ending February 28, 2007,	{W 331}	The DON met with the Designated Nurse and the QMRP. The DON explained the expected review and sign-off protocol to the DN and QMRP. The DN reviews and signs each shift log daily so that should health care concerns arise they can be quickly noted and addressed.	4/22/07

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G171	A. BUILDING _____ B. WING _____	R-C 03/01/2007

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{W 331}	Continued From page 8 the facility failed to provide nursing services in accordance with specified client needs. The findings include: According to the facility's 2/12/07 Plan of Correction, the facility's Director of Nursing was to develop a "supervision protocol" for all Designated Nurses. This protocol was to be develop to ensure that equipment and supplies required to assess and support clients' health care status and needs were readily available. At the time of the revisit, the facility was unable to provide evidence that these specific protocols had been developed. According to the Designated nurse, the Director of Nursing was in the process of revising all health care protocols. Contact was made with the facility's Director of Operations later that day to inform her of the findings of the revisit. It was verified that a supervision protocol was in the process of being developed and would be forwarded. 2. Interview conducted with the House Manager on February 28, 2007, revealed that Client #2 was receiving medical oversite from a different Primary Care Physician, than the other six clients in the facility. Client #2's sister, who is her health care guardian (limited) reportedly, in August, 2006, terminated the client's health care services provided by the facility's PCP. The client's sister identified another physician to provide health care services. The facility staff however, voiced ongoing concerns that communication with the new PCP had been essentially non-existant. On the day of the revisit, the direct care staff went to the PCP's medical office to drop off several speciality consults documents and physican order sheets for signature and review. The staff	{W 331}	Surveyors requested the DON to provide a copy of the specific protocols related to supervision for all Designated Nurses. The protocol was forwarded per the request, but has since been sent to the DCHRP for additional review and comment. The PCP for client #2 received an additional letter from the DoDS in March 2007, and the contract for services was signed about 30 days later. The medical guardian and the Governing Body have been in agreement that client #2 should be discharged. DDS referred client #2 to a HCB Waiver provider approved by the guardian. Client #2 will be discharged from the facility by April 15, 2007.	4/22/07 4/22/07

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
OMB NO. 0938-0391

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{W 331}	Continued From page 9 returned and stated that the receptionist told them it could take up to 10 working days for the PCP to review, sign off and to make recommendations if warranted. The staff returned to the facility with no documents or evidence of the visit. On March 1, 2007 three sheets and forms were observed in the front pocket of Client #2's Medical Book. A notation was written on the side "Sent to Dr. < > on 3/1/07 for review.(GYN-10/9/06, PT-11/15/06, and Orthopedic-1/31/07). To date, there was no evidence that the facility's new Director of Nursing had met with Client #2's new primary care physican to establish a relationship, to establish a clear line of communication, to ensure timely visits and assessments, to ensure timely review of outside specialist reports and recommendations and to order medications when changes were warranted, timely. ********** ********** Based on interview and record review, the facility nursing staff failed to provide nursing services in accordance with Client #1's health needs. The findings include: 1.The facility's Register Nurse and the Designated nurse failed to assessed Client #1's health care needs timely after a significant change had occurred in her health status. Interviews conducted with the facility staff on January 18 and January 22, 2007 revealed that prior to Client #1's hospitalization on November 26, 2006, she had been experiencing severe lethargy with refusals to eat or drink and to take her medications, for over a 24 hour period. She	{W 331}	The previous RN is no longer with the agency. A DON and a full time RN have been hired. The DON provides supervision of the RN. The RN provides close supervision of the DN and facility staff, ensuring that clients' health needs are continually monitored and that appropriate, timely interventions occur.	4/22/07

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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OMB NO. 0938-0391

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{W 331}	Continued From page 10 also had been running a temperature of 101.3. Review of the records revealed that Client #1 had been hospitalized numerous times from March to November 26, 2006 (3/28/06, 9/26/-10/12/06; 10/25/06-11/07/06), due to exhibiting similar symptoms. The RN and the Designated nurse were aware of the severity of her symptoms based on the November 6, 2006 meeting they participated in at the hospital, however failed to ensure that Client #1's needs were timely assessed. Client #1's symptoms continued after a 24 hour period and only at that time, the determination for her to be taken to the Emergency room was made by the medication nurse. At no time during the 24 hour period (Novemver 25-26, 2006), did the RN or the designated nurse come to see Client #1 or recommend, based on the severity of her symptoms, that 911 be called. 2. Cross refer to W192. The facility nurse failed to effectively train staff on Client #1's health care needs. 3. The facility nurse failed to ensure all necessary equipment, to assess the clients, was available at all times. Review of the facility's 11/30/06 investigation revealed on the onset of client #1 illness (November 25, 2006), the nurse was unable to measure her blood pressure. Reportedly, the facility's stethoscope was missing. The facility failed to have a method to ensure that all medical equipment was available and operational. 4. There was no evidence that the facility nurses were reviewing Client #1's Health Monitoring Record ". Interview with the direct care staff	{W 331}	The RN to which this finding refers is no longer employed by the facility. The DON has developed and delivered effective training to facility staff on all clients' health care needs. The DON and new RN provide a daily check to ensure that equipment is present and in working order. The "Health Monitoring Book" has been replaced by the 24-hour medical shift log. The log is individualized and gives clear direction on documenting fluids intake, BMs, repositioning, and meal intake; it is reviewed daily by the DN.	4/22/07 4/22/07 4/22/07

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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OMB NO. 0938-0391

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{W 331}	Continued From page 11 revealed that each client in the facility has a " Health Monitoring Record". The staff were responsible daily, to document on a fluid intake, bowel movement, repositioning and meal intake form. Review of Client #1's Health Monitoring record failed to evidence that the RN and/or the Designated nurse had reviewed the data and transferred the information into the medical record summaries. In addition, none of the data sheets were individualized and failed to provide specific directions, such as how much fluids were to be offered, how many days without a bowel movement before notifying the nurse, etc. There was also days that staff did not document.	{W 331}		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G171	A. BUILDING _____ B. WING _____	03/14/2007

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CARECO 11	4501 GRANT STREET, NE WASHINGTON, DC 20019

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I 000	INITIAL COMMENTS A licensure survey was conducted from February 28, 2006 to March 5, 2007. The GHMRP ' s census at the time of the survey was seven, (one male and six females); with varying degrees of mental retardation. Four residents were selected for the sample. Based on concerns regarding the safety and health care of Resident #2 the survey was extended. The facility's QMRP and management staff were notified that the survey was extended on March 3, 2007 at 11:30 a.m. In addition, an investigation into the health care of Resident #2 was conducted in conjunction with the survey. The findings were based on observations at the group home and two day programs as well as the review of the medical and administrative records including the unusual incidents. On March 8, 2007 and March 12, 2007, the Department of Health received three additional incidents alleging the GHMRP's failure to protect its residents from abuse and neglect. On March 13, 2007 the State agency determined based on the nature of the incidents and the findings at the closure of the recertication survey on March 5, 2007, an extended review of the facility practices were warranted to include these three incidents: Incident #1 On March 7, 2007, Staff #1 left the GHMRP for an unspecified period of time, leaving her assigned 1:1 client without appropriate supervision. Incident #2 On March 7, 2007. Staff #2 left the GHMRP for an unspecified period of time, leaving his assigned 1:1 client without appropriate supervision.	I 000		

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Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G171	A. BUILDING _____ B. WING _____	03/14/2007

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CARECO 11	4501 GRANT STREET, NE WASHINGTON, DC 20019

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I 000	Continued From page 1 Incident #3 On March 12, 2007, the group homes internal investigation findings revealed that Resident #4 had been verbally abused by the house manager, which was witnessed by Staff #1 and #2. On March 13-14, 2007 an onsite extended survey was conducted, to include additional staff and administrative interviews, observations and record verification. Based on the interviews with the GHNRP staffing and one resident interview (Resident #4), the aforementioned allegations of neglect and verbal abuse were substaniated. Based on these finding, the provider administrator was notified on March 14, 2007 at 3:45 PM, that the GHMRP was not incompliance with Governing Body and Management and Facility Staffing.	I 000		
I 040	3502.1 MEAL SERVICE / DINING AREAS Each GHMRP shall provide each resident with a nourishing, well-balanced diet. This Statute is not met as evidenced by: Based on observation, interview, and record review the GHMRP failed to serve each resident with a nourishing, well-balanced diet. The finding includes: See Federal Deficiency Report Citation W474	I 040	See response to federal deficiency W474	
I 052	3502.10 MEAL SERVICE / DINING AREAS Each GHMRP shall equip dining areas with tables, chairs, eating utensils, and dishes	I 052	See response to federal deficiency W484.	

Health Regulation Administration

PRINTED: 03/26/2007
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G171	A. BUILDING _____ B. WING _____	03/14/2007

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CARECO 11	4501 GRANT STREET, NE WASHINGTON, DC 20019

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I 052	Continued From page 2 designed to meet the developmental needs of each resident. This Statute is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that residents owned and/or consistently utilized prescribed adaptive equipment, for one of the four residents in the sample. (Resident #4) The finding includes: During the morning observation on February 28, 2007 at 7:35 AM, staff were observed asking each client if they would like a cup of water. Client #4 requested at that time if she could have something to drink. It was noted that all of her peers were drinking at the time. The direct care staff told her that she would have to wait for something to drink because her adaptive cup was in the dishwasher and the dishwasher was already running. At 8:00 AM and at 8:10 AM, Client #4 asked again for something to drink, however, prior to her leaving the facility for her day program, she was not observed receiving anything to drink as requested. Interview with the QMRP on the same day acknowledged the need for another adaptive cup for Client #4.	I 052		
I 057	3502.15 MEAL SERVICE / DINING AREAS Menus shall be written on a weekly basis, shall provide a variety of foods at each meal, and be varied from week to week and adjusted for seasonal changes.	I 057	The QMRP will request the Registered Dietician to provide menus for all seven clients served by the home for each day of the week. The Registered Dietician will be requested to provide a menu for portable lunches to be served to clients when they are away for medical appointments.	4.22-07

Health Regulation Administration

PRINTED: 03/26/2007
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G171	A. BUILDING _____ B. WING _____	03/14/2007

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I 057	Continued From page 3 This Statute is not met as evidenced by: Based on observation and interview, the GHMRP failed to ensure that menus included a lunch meal on a weekly basis for all seven residents in the facility. The finding includes: Observations during the environmental walk-through on March 5, 2006 at 11:21 AM revealed the facility provided menus, however, the menus did not include a lunch meal. Interview with the house manager revealed that the nutritionist has been scheduled to review the menus to include lunch menus to utilize during the week. Currently the lunch menus available were for Saturday and Sundays. At the time of the survey, the facility failed to provide evidence that menus included lunch meals on a weekly basis. It should also be noted that during the survey process, Resident #2 was sent out for a medical appointment that extended during his lunch time. Client #2's diet has been changed from a bite sized to pureed diet, with thick it to be added to his fluids. Upon their return to the group home, the direct care staff were interviewed to see when and how client #2 was fed. The staff indicated that they improvised and fed him mashed potatoes, applesauce and chocolate pudding. According to his physician orders he is to have 1800 calories a day and an ensure supplement at each meal. There was no evidence that the GHMRP had ensured that when residents have to be on medical appointments, that their dietary needs are met to ensure their health, safety and well being. There was also no evidence that the QMRP had notified the dietitian about these concerns.	I 057		

Health Regulation Administration

PRINTED: 03/26/2007
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G171	A. BUILDING _____ B. WING _____	03/14/2007

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I 090	Continued From page 4	I 090		
I 090	3504.1 HOUSEKEEPING The interior and exterior of each GHMRP shall be maintained in a safe, clean, orderly, attractive, and sanitary manner and be free of accumulations of dirt, rubbish, and objectionable odors. This Statute is not met as evidenced by: The findings include: During the environmental inspection on March 5,2007 the following concerns were observed: Bathroom 1. The bathroom located closest to the management's office was observed to have chipped and red stained grout between the tiles in the shower. The toilet based was observed to be loose and mobile to the touch. 2. The toilet in the large adaptive bathroom was observed to inoperable for two consecutive days. The toilet tank cover did not chipped and broken along the edges, a potential safety risk. 3. The bathroom adjacent to the kitchen had a facet that was leaking (water was observed on top of the sink). Kitchen 1. One of the cabinet doors near the refrigerator was missing. 2. The stove and the oven were observed to be dirty.	I 090	The facility is seeking permission from oversight agencies to move clients served to a new home located in a park- like area, close to but not negatively impacted by major thoroughfares. The proposed new home is in excellent repair. While awaiting permission to move, the current facility repairs noted in this standard will be corrected; appliances will be cleaned, working freezer thermometers will be installed.	4/22/07

Health Regulation Administration

PRINTED: 03/26/2007
FORM APPROVED

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I 090	Continued From page 5 3. The small freezer located in the dining room had inoperable temperature gauge. Evidence of pre-melted foods that were stored in this freezer that had to be thrown away. Bedroom 1. All seven residents person care kits, which stored toothbrushes, toothpaste, hygiene items were dirty. All electric toothbrushes were inoperable and worn. 2. All seven residents laundry baskets were observed busted with jagged plastic edges exposed. 3. Resident #5's dresser had 12 exposed nails, with pointed end protruding out, where the front part of a drawer will missing, a potential safety risk to both the client and the staff being injured. 4. Numerous items were observed stored in the furnace room. (old wheelchair, boxes, window screens and two cans of paint) Inside the furnace room there was a note posted documenting per the fire inspector, no items were to be stored in the furnace room.	I 090	All personal care kits will be replaced, hygiene items will be replaced, electric toothbrushes will be replaced. Laundry hampers/baskets will be replaced. Dresser nails will be removed. The furnace room will be cleaned out.	4/22/07
I 161	3507.2 POLICIES AND PROCEDURES The manual shall be approved by the governing body of the GHMRP and shall be reviewed at least annually. This Statute is not met as evidenced by: Based on interview and record review, the GHMRP governing body failed to review its policies and procedures annually.	I 161	The Governing Body is reviewing and revising all of its policies. The DCHRP is assisting by reviewing all health related policies for best practices. The Governing Body has set a procedure for annual review and revision (as needed) of all policies governing the facility.	4/22/07

Health Regulation Administration

PRINTED: 03/26/2007
FORM APPROVED

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I 161	Continued From page 6 The finding includes: Interview and review of the policy and procedure manual on on March 5, 2007 failed to provide evidence that the agency's policy manual had been reviewed and approved by the governing annually as required. The last noted date for review was in 2/6/06.	I 161		
I 203	3509.3 PERSONNEL POLICIES Each supervisor shall discuss the contents of job descriptions with each employee at the beginning employment and at least annually thereafter. This Statute is not met as evidenced by: Based on record review, the GHMRP failed to have on file for review current job descriptions for all employees annually. The finding includes: Review of the personnel files conducted on March 5, 2007, revealed that GHMRP failed to provide evidence of current signed job descriptions for five (5) direct care staff (TS, NC, ED,SF and RS).	I 203	Each supervisor will annually review each employee's job description with him or her annually, and the supervisor and the employee will sign the review certifying that it has taken place, and that the employee understands required duties.	4/22/07
I 206	3509.6 PERSONNEL POLICIES Each employee, prior to employment and annually thereafter, shall provide a physician ' s certification that a health inventory has been performed and that the employee ' s health status would allow him or her to perform the required duties.	I 206	The QMRP will monitor the personnel files periodically to ensure that each direct service employee has a current health certificate stating he or she is free from communicable disease.	4/22/07

Health Regulation Administration

PRINTED: 03/26/2007
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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I 206	Continued From page 7 This Statute is not met as evidenced by: Based on record review, the GHMRP failed to have on file for review current health certificates for all employees annually. The finding includes: Review of the personnel files on March 5, 2007, the GHMRP failed to provide current health certification for one (1) direct care staff [ED], and one consultant (MC).	I 206		
I 228	3510.5(e) STAFF TRAINING Each training program shall include, but not be limited to, the following: (e) Resident ' s rights; This Statute is not met as evidenced by:	I 228	See response to federal deficiencies W159, W318, W322; W104, W130, W148, W149, W158, W189, W122, W193, W369, W385, W436, W448, W474.	
I 229	3510.5(f) STAFF TRAINING Each training program shall include, but not be limited to, the following: (f) Specialty areas related to the GHMRP and the residents to be served including, but not limited to, behavior management, sexuality, nutrition, recreation, total communications, and assistive technologies; This Statute is not met as evidenced by:	I 229	See response above.	

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FORM APPROVED

Health Regulation Administration

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	09G171	A. BUILDING _____ B. WING _____	03/14/2007

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I 246	Continued From page 8	I 246		
I 246	3511.4 DIRECT CARE STAFF RATIOS The initial daily direct care staff ratios shall be determined by the Department of Human Services (DHS) based upon the characteristics of the individuals proposed to be served or served by the GHMRP as described in the Individual Habilitation Plans or based upon the GHMRP ' s description of the individuals to be served. This Statute is not met as evidenced by:	I 246	See response to federal deficiency W130.	
I 390	3520.1 PROFESSION SERVICES: GENERAL PROVISIONS Each resident of a GHMRP, regardless of his or her age or degree of disability, shall receive the professional services required to meet his or her needs as identified in his or her individual habilitation plan in accordance with the current " Outcome Performance Measures " from the " Council on Quality and Leadership in Support for People With Disabilities " (Council) and to the extent of funds appropriated for purposes of D.C. Law 2-137, as amended. This Statute is not met as evidenced by: The finding includes: Interview with the nurse revealed that the pharmacist conducts quarterly drug reviews. Record verification on March 1, 2007 at 8:05 AM revealed no drug regimen review was conducted for Client #4 between October 11, 2006 and March 1, 2007. There was no evidence that the drug reviews were conducted at least quarterly.	I 390	See response to federal deficiency W362.	

PRINTED: 03/26/2007
FORM APPROVED

Health Regulation Administration

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I 395	Continued From page 9	I 395		
I 395	3520.2(e) PROFESSION SERVICES: GENERAL PROVISIONS Each GHMRP shall have available qualified professional staff to carry out and monitor necessary professional interventions, in accordance with the goals and objectives of every individual habilitation plan, as determined to be necessary by the interdisciplinary team. The professional services may include, but not be limited to, those services provided by individuals trained, qualified, and licensed as required by District of Columbia law in the following disciplines or areas of services: (e) Nursing; This Statute is not met as evidenced by: The findings include: 1. The nursing staff failed to have policy and procedures for control testing of the glucometer as evidenced below: During the medication pass observation on March 1, 2007 at 4:10 p.m. the nurse was observed performing a blood glucose measurement utilizing an glucometer. Interview with the facility's Designated Nurse on the same day to ascertain what procedures were in place to ensure quality control of the glucometer, she indicated that there was no policy/procedure in place and that she takes it upon herself to perform the testing on the machine, however she does not document the results anywhere. Review of the manufactures manual revealed the recommendaion to perform control testing on the machine. It should be noted that this matter was refered to	I 395	See response to federal deficiency W393.	

PRINTED: 03/26/2007
FORM APPROVED

Health Regulation Administration

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	09G171	A. BUILDING _____ B. WING _____	03/14/2007

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I 395	Continued From page 10 the laboratory surveyor for review on March 2, 2007 at 10:00 a.m. 2. The nursing staff failed to ensure the timely completion of medical appoitments as evidenced below: Cross refer to W322. The nursing staff failed to ensure the timely completion of audiology appointments (W322.1) ENT appointments (W322.2) and Dental appointments (W322.3) Interview with the facility's nurse and QMRP on March 3, 2007, at 2:30 p.m. revealed that Client #2's behavior support plan indicated that after three failed attempts at an appointment, the client could be sedated, however, the nurse nor the QMRP could verify when (historically) Client #2 had successfully completed the aformentioned appointments. It could not be determined if the Client #2's Audiologic, ENT or Dental status had changed or remained the same as no historical data was available for review. 3. The nursing staff failed to ensure Client #2 received water via spoon as recommended by the speech therapistas evidenced by the following: On March 2, 2007, at 12:30 p.m. Client #2 was observed receiving a pureed diet for lunch. Interview with the Qualified Mental retardation Professional (QMRP) on March 2, 2007 at 2:00 PM revealed that the client was on a "chopped with ground meats" diet until he had a Swallow Study on January 4, 2007, which revealed that the Client had 'moderately severe oropharyngeal dsyphagia. The safe food textures recommended was creamy or thick pureed and the safe liquid consistencies was honey. The swallow function report also indicated that the	I 395	See response to federal deficiency W322. See response above.	

Health Regulation Administration

PRINTED: 03/26/2007
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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I 395	Continued From page 11 liquids should be given by spoon only. It should be noted that although thickener was added to Client #2's liquids, he was served the liquids through a cup. It was also noted that Client #2 coughed intermittently while receiving fluids by cup. There was no evidence that the nursing staff clarified the need to have the liquids served via spoon. 4. The nursing staff failed to verify how much thickener was needed for each type of liquid to ensure the proper consistency as evidenced below: Observations at the group home on March 14, 2007, at 11:30 a.m. revealed the nurse and the Administrator preparing to give Client #2 a can of Ensure Plus. The nurse placed 2 scoops of thickener in the cup, the Administrator stirred the liquid and, as it was not the right consistency, requested that more thickener be placed in the cup. It was evident that no clear guidelines were given to the facility as to the proper amount of thickener to use to ensure a honey thick consistency for the ensure. Interview with the Administrator and the nurse acknowledged the need for clarification and further guidance from the nutritionist.	I 395		
I 500	3523.1 RESIDENT'S RIGHTS Each GHMRP residence director shall ensure that the rights of residents are observed and protected in accordance with D.C. Law 2-137, this chapter, and other applicable District and federal laws.	I 500	See response to federal comment W000; see response to federal deficiencies W104, W122, W124, W125, W130, W136, W140, W148, W149, W154, W158, W159, W186, W189, W193, W214, W249, W263, W322, W331, W356, W436, W448, W474, and W484.	

Health Regulation Administration

PRINTED: 03/26/2007
FORM APPROVED

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I 500	Continued From page 12 This Statute is not met as evidenced by: Based on observation, interview and record review, the GHMRP failed to ensure the rights of residents were observed and protected in accordance with D.C. Law 2-137, Chapter 19, and other applicable District and Federal Laws. The findings include: The GHMRP failed to ensure residents' rights prescribed in D.C. Law 2-137, Chapter 19 as evidenced by the following deficiencies: 1. Section 7-1305.10 Mistreatment, neglect of abuse prohibited. The facility failed to protect its residents from harm and to ensure their general safety and well being. On March 8, 2007, an unusual incident report was received alleging neglect. Through further staff interview and record review on March 13, 2007 the allegation was substantiated based on the following: On March 13, 2007, interview with the direct care staff verified that on March 7, 2007, two direct care staff left the facility to buy food; leaving two staff in the facility to care for seven clients, three of which required 1:1 supervision, and one that required additional close supervision secondary to his recent surgery. Interview with the facility administrator on March 14, 2007 around 3:30 PM acknowledged that the facility had been initally short of staff and the two staff leaving failed to adhere to agency policy.	I 500		

Health Regulation Administration

PRINTED: 03/26/2007
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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I 500	Continued From page 13 2. On March 12, 2007, the facility had identified and forwarded an incident report to the Department of Health , that alledged that Resident #4 had been subjected to verbal abuse by the facility's house manager, which was witnessed by the two employees involved in the March 7, 2007 incident. On March 13. 2006 at approximately 3:00 PM, Resident #4 was interviewed to verify if she had been verbally abused. Resident #4 revealed that she had been spoken too harshly by the house manager and was afraid of her. She further stated that she had been threaten with physical harm, if she said any thing to any one. On March 13, 2007 around 4:15 PM, staff were interviewed which verified the clients statement that the house manager had interacted inappropriately (verbally) with resident #4. During the course of staff interviews, it was reported, that 3 additional residents that reside in this facility had also been subjected to inappropriate comments by the house manager to include comments referencing these residents as "lip tracy", "big black gorilla", and "go around the corner to your crack head moma's house". Staff stated that they knew that this was abuse and that it was wrong, however failed to report the abuse as indicated in the agencies policy and procedures. Each staff stated that their jobs had been threaten and felt that administration would not support them if they reported the abuse. Staff also stated that they had received recent training on abuse and neglect, client rights and incident reporting (February 24, 2007), stating that the abuse should have documented on an unusual incident report. Review of the GHMRP's policy and procedures on Abuse and Neglect classified that verbal abuse as a "misdemeanor." When the	I 500		

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	09G171	A. BUILDING _____ B. WING _____	03/14/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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I 500	Continued From page 14 surveyors brought the aforementioned allegations to the adminstrators attention on March 14, 2007 at 3:20 PM, it was acknowledge that the agency was aware of the other clients indentified through their internal investigation efforts, however had not reported the allegations to the police. At that time, the facility administrator made contact with the police to file an report. The administrator also informed the surveyors that the agencies investigation had been completed and witht the recommendation to terminate the house manager. The administrator also verified that the agency's policy and procedures were in need of revision to include employee protection and reporting methods for employees who have witnessed abuse. 3. The facility failed to provide effective monitoring supervision to ensure Client #2 was not exposed to the foreign bodies that he ingested. On February 28, 2007, at 9:00 a.m. Client #2 was observed sitting in the living room area with the direct care staff and his peers. Interview with the residential manager at 10:00 a.m. revealed that client #2 would not be attending his day program because he had a medical appointment. further interview with the residential manager revealed that Client #2 had just had abdominal surgery. Interview with the Designated Nurse and the QMRP on the same day revealed that Client #2 went to have an esophogastroduodinoscopy (EGD) on an outpatient basis on January 24, 2007. A foreign body was observed in the stomach. In an attempt to remove the foreign body, the client aspirated. Client #2 was received emergency surgery to remove the foreign body. According to the operative report, twelve (12) plastic bags were removed from the clients	I 500		

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I 500	Continued From page 15 stomach. Further interviews with the Designated Nurse and QMRP on March 3, 2007 at 3:00 p.m. and the on the same day revealed that it was not known how the client came to have access to the plastic bags. Interview with direct care staff #1 on March 5, 2006 revealed that Client #2 is capable of reaching for objects that he wants. Review of the facility's internal investigation into this matter failed to evidence interviews and/or possible theories as to how the client came to have 12 plastic bags in his stomach. 2. The GHMRP failed to ensure the right of Resident #2 to receive meals in accordance with his specially-prescribed diet. D.C. Law 2-137, Section 6-1965(f) "Each customer has the right to a nourishing... diet, and where ordered by a physician and/or nutritionist, to a special diet." On February 28, 2007 Resident #2 was sent out for a medical appointment that extended during his lunch time. Client #2's diet has been changed from a bite sized to pureed diet, with thick it to be added to his fluids. Upon his return to the group home, the direct care staff were interviewed to see when and how client #2 was fed. The staff indicated that they improvised and fed him mashed potatoes, applesauce and chocolate pudding. According to his physician orders he is to have 1800 calories a day and an ensure supplement at each meal. There was no evidence that the GHMRP had ensured that when residents have to be on medical appointments, that their dietary needs are met to ensure their health, safety and well being. There was also no evidence that the QMRP had notified the dietitian	I 500		

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I 500	Continued From page 16 about these concerns. 3. The GHMRP failed to ensure that Resident #2 received dental services timely. D.C. Law 2-137, Section 6-1965(g) "Each customer shall have a right to prompt and adequate medical attention for any physical ailments..." Review of the dental section of Client #2 ' s medical record on March 2, 2007 at 10:45 a.m. revealed a consultation dated July 20, 2006 that indicated services were not rendered secondary to the pre-authorization was expired. On November 21, 2006, the consultation indicated that the client was not seen. No reason was indicated, however, there was a recommendation to " please sedate. " On January 18, 2007, the dental consultation report indicated that it was a re-call examination. The client had " moderate calculus deposits " " patient needs scaling, " " will submit pre-authorization. " Interview with the QMRP and the House manager on March 2, 2007, revealed that they rely on the physician's office to call and let them know when the office received the authorization for the appointments. The QMRP acknowledged the need for a better sysytem to ensure dental appointments are completed timely. 3. The GHMRP failed to document that Resident #1's legally-authorized surrogate health care decision-makers (his parents) received a full explanation of the potential risks and benefits associated with the resident's medication regimen, to include securing written consent from the parents. D.C. Law 2-137, Section 6-1965(h) "All customers have a right to be free from	I 500		

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I 500	Continued From page 17 unnecessary or excessive medication..." See Federal Deficiency Report - Citations W124, W125 and W263 4. The GHMRP failed to show evidence that Resident #1, #2 , #3 and #4s personal funds were spent in accordance with the plan set forth by the interdisciplinary team. Review of Client #1, #2, #3 and #4's financial records on March 5, 2007 at 10:00 AM revealed several withdrawals that had been deducted from their accounts between September 21 and 28, 2006. A review of each clients' record revealed that a withdrawal for $292.50 and $100 dollars had been withdrawn from each account, a total sum of $392. 50. Interview with the House Manager (HM) on March 5, 2007 at 2:30 PM revealed that the Qualified Mental Retardation Professional (QMRP) had been working with a vacation planner, and the sum above had been withdrawn for payment of vacation rental and the rest for spending money, however the trip never occurred. Interview with the QMRP later that afternoon confirmed that the vacation had been cancelled and the monies should have been re-deposited into each clients account. At the time of the survey, the facility was unable to account for the $392.50 withdrawn for each client. 5. 1. Facility staff failed to ensure resident privacy during personal care, for one of the seven residents residing in the facility. D.C. Law 2-137, Section 6-1901(2) "Secure for each resident of the District of Columbia with mental retardation...habilitation as will be suited to the needs of the person, and to assure that such habilitation is skillfully and humanely provided with full respect for the	I 500		

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I 500	Continued From page 18 person's dignity and personal integrity..." See Federal Deficiency Report Citation-W130	I 500		